medical
certificate of coverage
2010

Citigroup

selecthealth℠

2010 MEDICAL BENEFIT CHANGES

The following information is a summary of significant changes and clarifications made for 2010 plans. This is not a legal document. The complete language will be available in the 2010 Certificate of Coverage. These changes are effective January 1, 2010, for new and renewing business.

New Certificate of Coverage

This concise, member-friendly document will replace the existing Membership Guide. Additional member materials will be created to advise members about using their benefits and promote our value-added services.

Cochlear Implants

Bilateral and unilateral cochlear implants will be covered up to a $35,000 lifetime maximum plan payment. Coverage will apply to fully funded, Small Employer, and Individual plans, and will be optional for self-funded groups. Services must be performed by participating providers to be eligible for benefits.

Durable Medical Equipment (DME)

The $1,500 limit that currently applies to certain DME items will be removed, and preauthorization requirements introduced in January 2009 have been slightly modified. The following DME requires preauthorization:

- Insulin pumps and continuous glucose monitors;
- Prosthetics (except eye prosthetics);
- Negative pressure wound therapy electrical pump (wound vac);
- Motorized or customized wheelchairs; and
- DME with a purchase price over $5,000.

Note: *Preauthorization requirements will change January 1, 2010. The limit will be removed as groups renew, beginning January 1, 2010.*

Dental Anesthesia

The criteria for dental anesthesia have been modified for 2010. Coverage has been expanded to provide benefits for members who are developmentally delayed or who have cardiac or neurological conditions, regardless of age. Complete language will be available for members in the 2010 Certificate of Coverage.

Switch to Paperless Statements.

You can now go paperless by choosing to receive only online claims on My Health, our secure member Web site. You can access current and previous medical claims, year-to-date totals, and member discounts for your family.

Register and log in by going to www.SelectHealth.org/MyHealth. If you haven't registered for My Health, have your ID card handy.

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MEMBER PAYMENT SUMMARY

PARTICIPATING

(In-Network)

When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies).

CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	$2,500,000
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	calendar year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET	**PARTICIPATING**
Deductible - Per Person/Family (per calendar year)	$500/$1000
Out-of-Pocket Maximum - Per Person/Family (per calendar year)	$3000/$6000
	(Deductible Included)
INPATIENT SERVICES	**PARTICIPATING**
Medical, Surgical, Hospice, and Emergency Admissions	10% after deductible
Maternity and Adoption [1]	10% after deductible
Skilled Nursing Facility - Up to 60 days per calendar year	10% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational	10% after deductible
Up to 40 days per calendar year for all therapy types combined	
PROFESSIONAL SERVICES	**PARTICIPATING**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP) [2]	10% after deductible
Secondary Care Provider (SCP) [2]	10% after deductible
Preventive Care	
Primary Care Provider (PCP) [2]	Covered 100%
Secondary Care Provider (SCP) [2]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	10%
Diagnostic Tests: Minor [3]	Covered 100%
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	10% after deductible
Major Office Surgery *(Surgical and Endoscopic Services Over $350)*	10% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	10% after deductible
OUTPATIENT SERVICES	**PARTICIPATING**
Outpatient Facility and Ambulatory Surgical - *(all related services)*	10% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	10% after deductible
Emergency Room - *(Participating facility) - Includes all services rendered in conjunction with the ER*	10% after deductible
Emergency Room - *(Nonparticipating facility) - Includes all services rendered in conjunction with the ER*	10% after deductible
Intermountain InstaCare℠ Facilities, Urgent Care Facilities	10% after deductible
Intermountain KidsCare℠ Facilities	10% after deductible
Chemotherapy, Radiation and Dialysis	10% after deductible
Diagnostic Tests: Minor [3]	Covered 100% after deductible
Diagnostic Tests: Major [3]	10% after deductible
Home Health, Hospice, Outpatient Private Nurse	10% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational	10% after deductible
Up to 20 visits per calendar year for each therapy type	

See other side for additional benefits

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MEMBER PAYMENT SUMMARY

PARTICIPATING
(In-Network)

MISCELLANEOUS SERVICES	PARTICIPATING
Durable Medical Equipment (DME) [4]	10% after deductible
Infertility - *Selected Services*	*50% after deductible
(Max Plan Payment $1,500/ calendar year; $5,000 lifetime)	
Miscellaneous Medical Supplies (MMS)	10% after deductible
Other Plan Payment Maximums	
Cochlear Implants - *Up to $35,000 lifetime*	See Physician's Fees and Inpatient or Outpatient Services benefits
Donor Fees for Covered Organ Transplants - *Up to $40,000 lifetime*	10% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	10% after deductible
BENEFIT RIDERS	**PARTICIPATING**
Mental Health and Chemical Dependency [7]	
Mental Health Office Visits	10% after deductible
Inpatient	10% after deductible
Outpatient	10% after deductible
Residential Treatment Center [7]	10% after deductible
Chiropractic - up to 20 visits per calendar year 1-800-678-9133	*$10
Injectable Drugs and Specialty Medications +	10% after deductible
PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per calendar year	*$50
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* +	
Tier 1	^*$10
Tier 2	^*$25
Tier 3	^*$45
Maintenance Drug Benefit-90 Day Supply (Medco by Mail or Retail90℠)-*selected drugs* +	
Tier 1	^*$10
Tier 2	^*$50
Tier 3	^*$135
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

1 SelectHealth provides an allowable adoption amount of $4,000 as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.

2 Refer to your SelectHealth Provider & Facility Directory to identify whether a provider is a primary or secondary care provider.

3 Refer to your Certificate of Coverage for more information.

4 Certain DME items require preauthorization for coverage. Refer to your Certificate of Coverage, or contact SelectHealth Member Services for more information.

7 All mental health and chemical dependency services require preauthorization with the exception of office visits.

+ Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your Certificate of Coverage for more information.

* Not applied to Medical out-of-pocket maximum.

^ After Pharmacy Deductible.

All deductible/copay/coinsurance amounts and plan payments are based on allowed amounts only and not on the provider's billed or other charges. You are responsible to pay for charges in excess of allowed amounts for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Refer to your Contract, Certificate of Coverage, or Provider & Facility Directory for more information.

Select Med is administered and underwritten by SelectHealth.

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SECTION 1—INTRODUCTION

1.1 This Certificate.

This Certificate of Coverage describes the terms and conditions of the health insurance Benefits provided under your employer's Group Health Insurance Contract with SelectHealth, Inc. Please read it carefully and keep it for future reference. Technical terms are capitalized and described in Section 16—Definitions. Your Member Payment Summary, which contains a quick summary of the Benefits by category of service, is attached to and considered part of this Certificate.

1.2 SelectHealth.

SelectHealth is an HMO licensed by the State of Utah. SelectHealth is affiliated with Intermountain Healthcare, but is a separate company. The Contract does not involve Intermountain Healthcare or any other affiliated Intermountain companies, or their officers or employees. Such companies are not responsible to you or any other Members for SelectHealth's obligations or actions.

1.3 Managed Care.

SelectHealth provides managed healthcare coverage. Such management necessarily limits some choices of Providers and Facilities. The management features and procedures are described by this Certificate. The Plan is intended to meet basic healthcare needs, but not necessarily to satisfy every healthcare need or every desire Members may have for Services.

1.4 Your Agreement.

As a condition to enrollment and to receiving Benefits from SelectHealth, you (the Subscriber) and every other Member enrolled through your coverage (your Dependents) agrees to:

a. the agency relationships set forth in this Certificate and the Contract;

b. the managed care features that are a part of the Plan in which you are enrolled; and

c. all of the other terms and conditions of this Certificate and the Contract.

1.5 No Vested Rights.

You are only entitled to receive Benefits while the Contract is in effect and you, and your Dependents if applicable, are properly enrolled and recognized by SelectHealth as Members. You do not have any permanent or vested interest in any Benefits under the Plan. Benefits may change as the Contract is renewed or modified from year to year. Unless otherwise expressly stated in this Certificate, all Benefits end when the Contract ends.

1.6 Administration.

SelectHealth establishes reasonable rules, regulations, policies, procedures, and protocols to help it in the administration of your Benefits. You are subject to these administrative practices when receiving Benefits, but they do not change the express provisions of this Certificate or the Contract.

1.7 Non-Assignment.

Benefits are not assignable or transferable. Any attempted assignment or transfer by any Member of the right to receive payment from SelectHealth will be invalid unless approved in advance in writing by SelectHealth.

1.8 Notices.

Any notice required of SelectHealth under the Contract will be sufficient if mailed to you at the address appearing on the records of SelectHealth. Notice to your Dependents will be sufficient if given to you. Any notice to SelectHealth will be sufficient if mailed to SelectHealth's principal office. All required notices must be sent by at least first class mail.

1.9 Nondiscrimination.

SelectHealth will not discriminate against any Member based on race, sex, religion, national origin, or any other basis forbidden by law. SelectHealth will not terminate or refuse to enroll any Member because of the health status or the healthcare needs of the Member or because he or she exercised any right under SelectHealth's complaint resolution system.

1.10 Questions.

If you have questions about your Benefits, call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038, or visit www.selecthealth.org. SelectHealth offers foreign language assistance.

1.11 Disclaimer.

SelectHealth employees often respond to outside inquiries regarding coverage as part of their job responsibilities. These employees do not have the authority to extend or modify the Benefits provided by the Plan.

a. In the event of a discrepancy between information given by a SelectHealth employee and the written terms of the Contract, the terms of the Contract will control.

b. Any changes or modifications to Benefits must be provided in writing and signed by the president, vice president, or medical director of SelectHealth.

c. Administrative errors will not invalidate Benefits otherwise in force or give rise to rights or Benefits not otherwise provided for by the Plan.

SECTION 2—ELIGIBILITY

2.1 General.

Your employer decides, in consultation with SelectHealth, which categories of its Employees, retirees, and their dependents are Eligible for Benefits, and establishes

the other Eligibility requirements of the Plan. These Eligibility requirements are described in this section and in the Group Application of the Contract. In order to become and remain a Member, you and your Dependents must continuously satisfy these requirements. No one, including your employer, may change, extend, expand, or waive the Eligibility requirements without first obtaining the advance, written approval of an officer of SelectHealth.

2.2 Subscriber Eligibility.

You are eligible for Benefits as set forth in the Group Application. During the Employer Waiting Period, you must work the specified minimum required hours except for paid time off and hours you do not work due to a medical condition, the receipt of healthcare, your health status or disability. SelectHealth may require payroll reports from your employer to verify the number of hours you have worked as well as documentation from you to verify hours that you did not work due to paid time off, a medical condition, the receipt of healthcare, your health status or disability.

2.3 Dependent Eligibility.

Unless stated otherwise in the Group Application, your Dependents are:

2.3.1 Spouse.

Your lawful spouse under the laws of the state where you reside. A person of the opposite sex to whom you are not formally married is your lawful spouse only if he or she qualifies as a common law spouse under the laws of the state where you reside at the time of enrollment. In Utah, you must obtain a court or administrative agency order establishing the common law marriage. Eligibility may not be established retroactively. In cases of court or administrative orders purporting to retroactively either establish or annul/declare void a marriage or divorce, SelectHealth will consider the change effective on the date the court or administrative order was signed by the court or administrative agency, or the date the order is received by SelectHealth, whichever is later.

2.3.2 Children.

The unmarried children (natural, adopted, and children placed for adoption or under legal guardianship through testamentary appointment or court order, but not under temporary guardianship or guardianship for school residency purposes) of you or your lawful spouse, who: (1) are under the Limiting Age; and (2) rely on you for more than half of their support (as described in Section 1.152-1 of the Internal Revenue Code).If paternity is in question when determining a Dependent child's Eligibility, the Eligible father must provide the Dependent child's birth certificate. If the Eligible father is not listed on the birth certificate, then he must provide a Voluntary Declaration of Paternity that complies with state law. Each of these documents must be notarized.

2.3.3 Disabled Children.

Dependent children who meet all of the Eligibility requirements in Subsection 2.3.2 except for age may enroll or remain enrolled as Dependents after reaching the Limiting Age as long as they: (1) are unable to engage in substantial gainful employment to the degree they can achieve economic independence due to medically determinable physical or mental impairment which can be expected to last for a continuous period of not less than 12 months or result in death; (2) are chiefly dependent upon you or your lawful spouse for support and maintenance since they reached the Limiting Age; and (3) have been continuously enrolled in some form of healthcare coverage, with no break in coverage of more than 63 days since the date they exceeded the Limiting Age for dependent children. SelectHealth may require you to provide proof of incapacity and dependency within 30 days of the Effective Date or the date the child reaches the Limiting Age and annually after the two-year period following the child's attainment of the Limiting Age.

Despite otherwise qualifying as described above, a person incarcerated in a prison, jail, or other correctional facility is not a Dependent.

2.4 Court-Ordered Dependent Coverage.

When you or your lawful spouse are required by a court or administrative order to provide health insurance coverage for a child, the child will be enrolled in your family coverage according to SelectHealth guidelines and only to the minimum extent required by applicable law.

2.4.1 Qualified Medical Child Support Order (QMCSO).

A QMCSO can be issued by a court of law or by a state or local child welfare agency. In order for the medical child support order to be qualified, the order must specify the following: (1) your name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order; (2) a reasonable description of the type of coverage to be provided, or the manner in which the coverage will be determined; and (3) the period to which the order applies.

2.4.2 National Medical Support Notice (NMSN).

An NMSN is a QMCSO issued by a state or local child welfare agency to withhold from your income any contributions required by the Plan to provide health insurance coverage for an Eligible child.

2.4.3 Eligibility and Enrollment.

You and the Dependent child must be Eligible for coverage, unless specifically required otherwise by applicable law. You and/or the Dependent child will be enrolled without regard to Annual Open Enrollment restrictions and will be subject to applicable Employer Waiting Period requirements. We will not recognize Dependent Eligibility for a former spouse as the result of a court order.

2.4.4 Effective Date.

For a qualified order, the Effective Date of coverage will be the later of:

a. the start date indicated in the order;

b. the date any applicable Employer Waiting Period is satisfied; or

c. The date we receive the order.

2.4.5 Duration of Coverage.

Court-ordered coverage for the Dependent child will only be provided until the sooner of: (1) the age stated in the order; or (2) age 18, except as required by Utah law.

SECTION 3—ENROLLMENT

3.1 General.

You may enroll yourself and your Dependents in the Plan during the Initial Eligibility Period, under a Special Enrollment Right, or, if offered by your employer, during an Annual Open Enrollment.

You and your Dependents will not be considered enrolled until:

a. all enrollment information is provided to SelectHealth; and

b. the Premium has been paid to SelectHealth by your employer.

3.2 Enrollment Process.

Unless separately agreed to in writing by SelectHealth and your employer, you must enroll on a Subscriber Application specified by SelectHealth. You and your Dependents are responsible for obtaining and submitting to SelectHealth evidence of Eligibility and all other information required by SelectHealth in the enrollment process. You enroll yourself and any Dependents by completing, signing, and submitting a Subscriber Application and any other required enrollment materials to SelectHealth.

3.3 Effective Date of Coverage.

Coverage for you and your Dependents will take effect as follows:

3.3.1 Annual Open Enrollment.

Coverage elected during your Employer's Annual Open Enrollment will take effect on the day the Contract is effective.

3.3.2 Newly Eligible Members.

Coverage you elect as a newly Eligible employee will take effect on the date specified in the Group Application if SelectHealth receives a properly completed Subscriber Application from your employer in a timely manner.

If you do not enroll in the Plan for yourself and/or your Dependents within 31 days of the date you first become Eligible, you may not enroll until the next Annual Open Enrollment unless you experience an event that creates a Special Enrollment Right.

3.4 Special Enrollment Rights.

SelectHealth provides Special Enrollment Rights in the following circumstances:

3.4.1 Loss of Other Coverage.

If you do not enroll in the Plan for yourself and/or your Dependents when initially Eligible, you may enroll at a time other than Annual Open Enrollment if each of the following conditions is met:

a. You initially declined to enroll in the Plan due to the existence of other health plan coverage;

b. The loss of the other health plan coverage occurred because of a loss of eligibility (this Special Enrollment Right will not apply if the other coverage is lost due to nonpayment of Premiums).There is an exception to this condition for Dependents who voluntarily drop their coverage under another large group health plan (more than 51 Subscribers) during an open enrollment period for the other large group health plan that does not coincide with your Employer's Annual Open Enrollment. A special enrollment period will be permitted for such Dependents in order to avoid a gap in coverage; and

c. You and/or your Dependents who lost the other coverage must enroll in the Plan within 31 days after the date the other coverage is lost.

Proof of loss of the other coverage (for example, a Certificate of Creditable Coverage) must be submitted to SelectHealth as soon as reasonably possible. Proof of loss of other coverage must be submitted before any Benefits will be paid.

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective on the date the other coverage was lost.

3.4.2 New Dependents.

If you are enrolled in the Plan (or are Eligible to be covered but previously declined to enroll), and gain a Dependents through marriage, birth, adoption, placement for adoption or placement under legal guardianship with you or your lawful spouse, then you may enroll the Dependents (and yourself, if applicable) in the Plan. In the case of birth, adoption or placement for adoption of a child, you may also enroll your Eligible spouse, even if he or she is not newly Eligible as a Dependent. However, this Special Enrollment Right is only available by enrolling within 31 days of the marriage, birth, adoption, placement for adoption or placement under legal guardianship (there is an exception for enrolling a newborn, adopted child, or child placed for adoption or under legal guardianship if enrolling the child does not change the Premium, as explained in

Section 3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship).

Coverage of any Members properly enrolled under this Special Enrollment Right will be effective as indicated:

a. As of the date of marriage;

b. As of the date of birth;

c. If the child is less than 31 days old when adopted or placed for adoption, as of the date of birth; if the child is more than 31 days old when adopted or placed for adoption, as of the child's date of placement; or

d. As of the later of:

   i. The effective date of the guardianship court order or testamentary appointment; or

   ii. The date the order is received by SelectHealth.

3.4.3 Divorce/Annulment of a Dependent Child's Marriage.

You may enroll a Dependent child who newly becomes (re)Eligible as the result of a divorce or an annulment of the child's marriage. You must enroll any such child within 31 days after the signing by the court of the order granting the divorce/annulment or wait until the next Annual Open Enrollment.

Coverage for any child properly enrolled under this Special Enrollment Right will begin on the effective date of the divorce/annulment if that date is within six months of the date of marriage. If the court signs the order granting the divorce/annulment more than six months from the date of marriage, coverage for any child properly enrolled will begin on the date the order is received by SelectHealth, without consideration of any retroactive effect stated in the order.

3.4.4 Qualification for a Subsidy Through Utah's Premium Partnership.

You and/or your Eligible Dependents who qualify for a subsidy through the state Medicaid program to purchase health insurance may enroll in the Plan if application is made within 30 days of receiving written notification of eligibility for the subsidy. If you timely enroll, the effective date of coverage is the first of the month following date of enrollment.

3.4.5 Loss of Medicaid or CHIP Coverage.

If you and/or your Eligible Dependents lose coverage under a Medicaid or CHIP plan due to loss of eligibility, you may enroll in the Plan if application is made within 60 days. If you enroll within 60 days, the effective date of coverage is the first day after your Medicaid or CHIP coverage ended.

3.5 Enrolling a Newborn, Adopted Child, or Child Placed for Adoption or Under Legal Guardianship.

You must enroll your newborn, adopted child, child placed for adoption or child under legal guardianship according to the following requirements:

a. If enrolling the child requires additional Premium, you must enroll the child within 31 days of the child's birth, adoption, or placement for adoption.

b. If enrolling the child does not change the Premium, you must enroll the child within 31 days from the date SelectHealth mails notification that a claim for Services was received for the child.

c. If the child is not enrolled within these time frames, then you may not enroll the child until your Employer's next Annual Open Enrollment.

d. If you lose Eligibility for coverage before the end of the applicable time frame listed in (a) or (b) above, you are still allowed to enroll the child within the applicable time frame. However, the child will only be covered from the moment of birth, adoption, placement for adoption or under legal guardianship until the date that you lost Eligibility for coverage.

3.6 Leave of Absence.

If you are granted a temporary leave by your employer, you and any Dependents may continue to be enrolled with SelectHealth for up to the length of time specified in the Group Application, as long as the monthly Premiums for your coverage are paid to SelectHealth by your employer. Military personnel called into active duty will continue to be covered to the extent required by law. A leave of absence may not be treated retroactively as a termination of employment.

3.7 Family Medical Leave Act.

If you are on a leave required by the Family Medical Leave Act (FMLA), SelectHealth will administer your coverage as follows:

a. You and your enrolled Dependents may continue your coverage with SelectHealth to the minimum extent required by the FMLA as long as applicable Premiums continue to be paid to SelectHealth by your employer;

b. If Premiums are not paid, your coverage will be terminated. Upon your return to work, you and any previously enrolled Dependents who are still Eligible will be prospectively reinstated if the applicable Premium for you is paid to SelectHealth by your employer within 30 days. SelectHealth will not be responsible for any claims incurred by you or your Dependents during this break in coverage;

Any non-FMLA leave of absence granted by your employer that could have been classified as FMLA leave will be considered by SelectHealth as an FMLA leave of absence.

SECTION 4—TERMINATION

4.1 Group Termination.

Coverage under the Plan for you and your Dependents will terminate when the Contract terminates.

4.1.1 Nonrenewal by Your Employer.

The Contract is generally issued on an annual basis. If it is not renewed by your employer, it will automatically terminate at the end of its term.

4.1.2 Termination by Employer.

Your employer may terminate the Contract, with or without cause, by providing SelectHealth with written notice of termination not less than 30 days before the proposed termination date.

4.1.3 Termination of Employer Group by SelectHealth.

SelectHealth may terminate the Contract for any of the following reasons:

a. Nonpayment of applicable Premiums by your employer.

b. Fraud or intentional material misrepresentation to SelectHealth by your employer in any matter related to the Contract or the administration of the Plan.

c. Your employer's coverage under the Contract is through an association and your employer terminates membership in the association.

d. Your employer fails to satisfy SelectHealth's minimum group participation and/or employer contribution requirements.

e. No Members live, reside, or work in the Service Area.

f. SelectHealth elects to discontinue offering a particular health benefit plan. If that happens, you will be given at least 90 days advance notice.

g. SelectHealth withdraws from the market and discontinues all of its health benefit plans. If that happens, you will be given at least 180 days advance notice.

4.2 Individual Termination.

Your coverage under the Plan may terminate even though the Contract with your employer remains in force.

4.2.1 Loss of Eligibility.

If you and/or your enrolled Dependents lose Eligibility, then coverage will terminate at the end of the month in which the loss of Eligibility occurred. However, if the Eligibility is lost as the result of a termination of employment, your employer may choose on a uniform and consistent basis to terminate coverage as of the date of termination of employment. If your Spouse loses Eligibility because you divorce, he or she ceases to be a Member at the end of the month in which the decree of divorce or annulment is granted (whether or not the decree finally decides all property, support, and custody issues).

4.2.2 Fraud or Misrepresentation.

a. During Enrollment.

i. Coverage for you and/or your Dependents may be terminated during the two-year period after you enroll if you or they make any material misrepresentation in connection with insurability.

ii. Coverage for you and/or your Dependents may be terminated at any time if you or they make any fraudulent misrepresentation in connection with insurability.

Please Note: If coverage is terminated as described above, the termination will relate back to the Effective Date of coverage.

b. After Enrollment. Coverage for you and/or your Dependents may be terminated if you or they commit fraud or make a material misrepresentation in connection with Benefits.

If coverage for you or your Dependents is terminated for fraud or material misrepresentation, you or they are allowed to reenroll 12 months after the date of the termination, provided the Contract is still in force. You will be given notice of this provision at the time of termination.

The termination from the Plan of a Dependent for cause does not necessarily affect your Eligibility or enrollment or the Eligibility or enrollment of your other Dependents.

4.2.3 Leaving the Service Area.

Coverage for you and/or your Dependents terminates if you no longer live, work or reside in the Service Area.

4.2.4 Annual Open Enrollment.

You can drop coverage for yourself and any Dependents during Annual Open Enrollment.

4.2.5 Retroactive Termination of Member.

If SelectHealth discovers that you or your Dependents remained enrolled when no longer Eligible, SelectHealth is entitled to retroactively terminate the coverage. SelectHealth is entitled to recover from you and/or your Dependents the amount of any Benefits you or they receive after losing Eligibility, minus any Premiums paid for Services you or they received after losing Eligibility.

4.3 Member Receiving Treatment at Termination.

All Benefits under the Plan terminate when the Contract terminates, including coverage for Members hospitalized or otherwise within a course of care or treatment. All Services received after the date of termination are the responsibility of the Member and not the responsibility of SelectHealth no matter when the condition arose and despite care or treatment anticipated or already in progress.

4.4 Reinstatement.

Members terminated from coverage for cause may not be reinstated without the written approval of SelectHealth.

SECTION 5—CONTINUATION/ CONVERSION COVERAGE

If your coverage terminates, you or your enrolled Dependents may be entitled to continue and/or convert coverage. For detailed information about

your rights and obligations under your Employer's Plan and under federal law, contact your employer.

5.1 COBRA, Utah mini-COBRA, or Alternative to COBRA/Utah mini-COBRA Coverage (Continuation Coverage).

You and/or your Dependents may have the right to temporarily continue your coverage under the Plan when coverage is lost due to certain events. The federal law that governs this right is called COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) and generally applies to employers with 20 or more employees. For employers with fewer than 20 employees, Utah law provides for mini-COBRA coverage. Utah law also provides for alternative coverage.

5.1.1 Employer's Obligation.

Continuation Coverage is an employer obligation. SelectHealth is not the administrator of Continuation Coverage procedures and requirements. SelectHealth has contractually agreed to assist your employer in providing Continuation Coverage in certain circumstances. It is your employer's responsibility to do the following in a timely manner: (1) notify persons entitled to Continuation Coverage, (2) notify SelectHealth of such individuals, and (3) collect and submit to SelectHealth all applicable Premiums. If the Contract is terminated, your Continuation Coverage with SelectHealth will terminate. Your employer is responsible for obtaining substitute coverage.

5.1.2 Minimum Extent.

Continuation Coverage will only be provided for the minimum time and only to the minimum extent required by applicable state and federal law. SelectHealth will not provide Continuation Coverage if you, your Dependents, or your employer fails to strictly comply with all applicable notices and other requirements and deadlines.

5.2 Conversion Coverage.

Under Utah law, you and/or your Dependents may have the right in certain circumstances to obtain coverage under a separate, individual policy after your coverage in the group Contract is terminated.

5.2.1 Notice.

Your employer is required to provide you written notification of your right to Conversion Coverage within 30 days of your losing coverage under the Plan.

5.2.2 Eligibility.

In order to be eligible for Conversion Coverage, you must:

a. have been continuously covered by the Plan for a period of six months immediately prior to the termination of your coverage;

b. have exhausted Continuation Coverage;

c. not have acquired other group coverage that covers all conditions that are covered under the Plan;

d. reside in the Service Area;

e. not have lost coverage under the Plan because you either failed to pay any required Premium contribution or committed fraud or made an intentional misrepresentation of material fact; and

f. submit a written application for Conversion Coverage within 60 days of losing your coverage under the Plan.

5.2.3 Conversion Coverage for Dependents.

You may elect Conversion Coverage on behalf of family members who were covered under the Plan on the date of termination. The only Dependents who may be added to your Conversion Coverage after it has been issued are Dependents who become eligible through birth, adoption, or court or administrative order.

If you are newly eligible for Conversion coverage, but are 65 and choose instead to enroll in Medicare, you may enroll your Dependents on Conversion Coverage for as long as they satisfy the Eligibility requirements.

If you choose to drop Conversion Coverage and enroll in Medicare because you turn 65, or in the event of your death, your Dependents may remain on Conversion Coverage for as long as they satisfy the Eligibility requirements.

5.2.4 Effective Date.

If you properly enroll, Conversion Coverage is effective on the date your coverage under the Plan terminates.

5.2.5 Premium.

Your Premium will likely increase but will be determined without reference to your health. You must submit your Premium to SelectHealth. Failure to make timely Premium payments will result in termination of Conversion Coverage.

5.2.6 Minimum Extent.

Conversion Coverage will only be provided for the minimum time and only to the minimum extent required by applicable law. SelectHealth will not provide Conversion Coverage if you, your Dependents, or employer fails to strictly comply with all applicable notice, and other requirements and deadlines.

5.2.7 Conversion Coverage May Be Different.

You will receive SelectHealth's standard contract for Conversion Coverage in effect at the time your coverage under the Plan terminates, which may contain otherwise lawful terms, conditions, and Benefits that are different from those under the Plan.

SECTION 6—PROVIDERS/NETWORKS

6.1 Providers and Facilities.

SelectHealth contracts with certain Providers and Facilities (known as Participating Providers and

Participating Facilities) to provide Covered Services within the Service Area. Not all available Providers and Facilities and not all categories of Providers and Facilities are invited to contract with SelectHealth.

6.2 Providers and Facilities not Agents/ Employees of SelectHealth.

Providers contract independently with SelectHealth and are not agents or employees of SelectHealth. They are entitled and required to exercise independent professional medical judgment in providing Covered Services. SelectHealth makes a reasonable effort to credential Participating Providers and Facilities, but it does not guarantee the quality of Services rendered by Providers and Facilities or the outcomes of medical care or health-related Services. Providers and Facilities, not SelectHealth, are solely responsible for their actions, or failures to act, in providing Services to you.

Providers and Facilities are not authorized to speak on behalf of SelectHealth or to cause SelectHealth to be legally bound by what they say. A recommendation, order, or referral from a Provider or Facility, including Participating Providers and Facilities, does not guarantee coverage by SelectHealth.

Providers and Facilities do not have authority, either intentionally or unintentionally, to modify the terms and conditions of the Plan. Benefits are determined by the provisions of the Contract.

6.3 Payment.

SelectHealth may pay Providers in one or more ways, such as discounted fee-for-service, capitation (fixed payment per Member per month), and payment of a year-end withhold.

6.3.1 Incentives.

Some payment methods may encourage Providers to reduce unnecessary healthcare costs and efficiently utilize healthcare resources. No payment method is ever intended to encourage a Provider to limit Medically Necessary care.

6.3.2 Payments to Members.

SelectHealth reserves the right to make payments directly to Members instead of to Nonparticipating Providers and/or Facilities.

6.4 Provider/Patient Relationship.

Providers and Facilities are responsible for establishing and maintaining appropriate Provider/patient relationships with you, and SelectHealth does not interfere with those relationships. SelectHealth is only involved in decisions about what Services will be covered and paid for by SelectHealth under the Plan. Decisions about your Services should be made between you and your Provider without reference to coverage under the Plan.

6.5 Continuity of Care.

SelectHealth will provide you with 30 days notice of Participating Provider termination if you or your Dependents are receiving ongoing care from that Provider. However, if SelectHealth does not receive adequate notice of a Provider termination, SelectHealth will notify you within 30 days of receiving notice that the Provider is no longer participating with SelectHealth.

If you or your Dependents are under the care of a Provider when affiliation ceases, SelectHealth will continue to treat the Provider as a Participating Provider until the completion of the care (not to exceed 90 days), or until you or your Dependent is transferred to another Participating Provider, whichever occurs first. However, if you or your Dependent is receiving maternity care in the second or third trimester, you or they may continue such care through the first postpartum visit.

To continue care, the Participating Provider must not have been terminated by SelectHealth for quality reasons, must remain in the Service Area, and agree to all of the following:

a. to accept SelectHealth's Allowed Amount as payment in full;

b. to follow SelectHealth's Healthcare Management policies and procedures;

c. to continue treating you and/ or your Dependent; and

d. to share information with SelectHealth regarding the treatment plan.

SECTION 7—ABOUT YOUR BENEFITS—MEDICAL

7.1 General.

You and your Dependents are entitled to receive Benefits while you are enrolled with SelectHealth and while the Contract is in effect. This section describes those Benefits in greater detail.

7.2 Member Payment Summary.

Your Member Payment Summary lists variable information about your specific Plan. This includes information about Copay, Coinsurance, and/ or Deductible requirements, Preauthorization requirements, visit limits, and expenses that do not count against the Out-of-Pocket Maximum.

7.3 Identification (ID) Cards.

SelectHealth will provide you with ID cards that will provide certain information about the Plan in which you are enrolled. Providers and Facilities may require the presentation of the ID card plus one other reliable

form of identification as a condition to providing Services. The ID card does not guarantee Benefits.

If you or your enrolled Dependents permit the use of your ID card by any other person not covered by the card, the card will be confiscated by SelectHealth or by a Provider or Facility and all rights of such Member under the Plan will be immediately terminated.

7.4 Medical Necessity.

To qualify for Benefits, Covered Services must be Medically Necessary. Medical Necessity is determined by SelectHealth's Medical Director or another Physician designated by Selecthealth. A recommendation, order or referral from a Provider or Facility, including Participating Providers and Facilities, does not guarantee Medical Necessity.

7.5 Benefit Changes.

Your Benefits may change if the Contract changes. Your employer is responsible for providing 30 days advance written notice of such changes.

7.6 Calendar-Year or Plan-Year Basis.

Your Member Payment Summary will indicate if your Benefits are calculated on a calendar-Year or plan-Year basis. Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a calendar-Year basis start over each January 1st.Out-of-Pocket Maximums, Limitations, and Deductibles that are calculated on a plan-Year basis start over each Year on the renewal date of the Contract.

7.7 Lifetime Maximums.

Your Member Payment Summary will specify any applicable Lifetime Maximums.

7.8 Participating Benefits.

You must use Participating Providers and Facilities to receive Benefits for Covered Services unless otherwise noted in the Contract. Participating Providers and Facilities have agreed to accept SelectHealth's Allowed Amount and will not bill you for Excess Charges.

7.9 Emergent Conditions.

Participating Benefits apply to emergency room Services regardless of whether they are received at a Participating Facility or Nonparticipating Facility. However, you will have a lower Copay and/or Coinsurance at a Participating Facility.

If you or your Dependent is hospitalized for an emergency in a Nonparticipating Facility:

a. You or your representative must contact SelectHealth within two working days, or as soon as reasonably possible; and

b. Once the Emergent Condition has been stabilized, you may be asked to transfer to a Participating Facility in order to continue receiving Participating Benefits.

7.10 Urgent Conditions.

Participating Benefits apply to Services received for Urgent Conditions rendered by a Participating Provider or Facility. Participating Benefits also apply to Services received for Urgent Conditions rendered by a Nonparticipating Provider or Facility more than 40 miles away from any Participating Provider or Facility.

7.11 Preauthorization.

You or your Provider are required to contact SelectHealth before you receive certain Services. Depending on the circumstances, your Benefits may be reduced or denied if you do not comply with this requirement. Refer to Section 11—Healthcare Management and your Member Payment Summary for details.

SECTION 8—COVERED SERVICES

You and your Dependents are entitled to receive Benefits for Covered Services while you are enrolled with SelectHealth and while the Contract is in effect. This section describes those Covered Services (except for pharmacy Covered Services, which are separately described in Section 9—Prescription Drug Benefits).Certain Services must be Preauthorized; failure to obtain Preauthorization for these Services may result in a reduction or denial of Benefits. Refer to Section 11—Healthcare Management for a list of Services that must be Preauthorized.

Benefits are limited; Services must satisfy all of the requirements of the Contract to be covered by SelectHealth. For additional information affecting Covered Services, refer to your Member Payment Summary and Section 10—Limitations and Exclusions.

8.1 Facility Services.

8.1.1 Educational Training.

Only when provided at a Participating Facility for diabetes or asthma.

8.1.2 Emergency Room (ER).

If you are admitted directly to the Hospital because of the condition for which emergency room Services were sought, the emergency room Copay, if applicable, will be waived.

8.1.3 Inpatient Hospital.

a. Semiprivate room accommodations and other Hospital-related Services ordinarily furnished and billed by the Hospital.

b. Private room accommodations in connection with a medical condition requiring isolation. If you choose a private room when a semiprivate room is available or isolation is not necessary, you are responsible for paying the difference between the Hospital's semiprivate room rate and the private room rate. However, you will not be responsible for the additional charge if the Hospital

only provides private room accommodations or if a private room is the only room available.

c. Intensive care unit.

d. Preadmission testing.

e. Short-term inpatient detoxification provided by a SelectHealth-approved treatment Facility for alcohol/drug dependency.

f. Maternity/obstetrical Services.

g. Services in connection with an otherwise covered inpatient Hospital stay.

8.1.4 Nutritional Therapy.

Only when provided at a Participating Facility for diabetes, anorexia nervosa, bulimia, polyphagia, or obesity.

8.1.5 Outpatient Facility and Ambulatory Surgical Facility.

Outpatient surgical and medical Services.

8.1.6 Skilled Nursing Facility.

Only when Services cannot be provided adequately through a home health program.

8.1.7 Urgent Care Facility.

8.2 Provider Services.

8.2.1 After-Hours Visits.

Office visits and minor surgery provided after the Provider's regular business hours.

8.2.2 Anesthesia.

If administered in connection with otherwise Covered Services and by a Physician certified as an anesthesiologist or by a Certified Registered Nurse Anesthetist (CRNA) under the direct supervision of a Physician certified as an anesthesiologist.

8.2.3 Dental Services.

Only in three limited circumstances:

a. When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical Provider whose primary practice is not dentistry or oral surgery.

b. When SelectHealth determines the following to be Medically Necessary:

i. maxillary and/or mandibular procedures;

ii. upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension; and

iii. orthognathic Services.

c. For repairs of physical damage to sound natural teeth, crowns, and the supporting structures surrounding teeth when:

i. such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;

ii. medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and

iii. repairs are initiated within one year of the date of the accident.

Orthodontia and the replacement/repair of dental appliances are not covered, even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

8.2.4 Dietary Products.

Only in the following limited circumstances:

a. For hereditary metabolic disorders when:

i. The Member has an error of amino acid or urea cycle metabolism;

ii. The product is specifically formulated and used for the treatment of errors of amino acid or urea cycle metabolism; and

iii. The product is used under the direction of a Physician, and its use remains under the supervision of the Physician.

b. In all other situations when:

i. The formula is used under the direction of a Physician and can only be obtained by prescription and through a pharmacy; or

ii. The formula is the Member's primary source of nutrition and is primarily given through a form of feeding tube; or

iii. The Member has gastrointestinal dysfunction (e.g., malabsorption) and the product is specifically designed to be used in the management of the condition that prevents his or her ability to maintain adequate weight.

8.2.5 Genetic Counseling.

Only when provided by a Participating Provider who is a certified genetic counselor.

8.2.6 Genetic Testing.

Only in the following circumstances and according to SelectHealth criteria:

a. Prenatal testing when performed as part of an amniocentesis to assess specific chromosomal abnormalities in women at high risk for inheritable conditions that can lead to significant immediate and/or long-term health consequences to the child after birth;

b. Neonatal testing for specific inheritable metabolic conditions (e.g., PKU);

c. When the Member has a more than five-percent probability of having an inheritable genetic condition and has signs or symptoms suggestive of a specific condition or a strong family history of the condition (defined as two or more first-degree relatives with the condition) and results of the testing will directly affect the patient's treatment; or

d. Pre-implantation embryonic genetic testing performed to identify an inherited genetic condition known to already exist in either parent's family which has the potential to cause serious and impactful medical conditions for the child.

8.2.7 Home Visits.

Only if you are physically incapable of traveling to the Provider's office.

8.2.8 Infertility Diagnosis and Treatment.

Only the following Services:

Fulguration of ova ducts, hysteroscopy, hysterosalpingogram, certain laboratory tests, and laparoscopy.

8.2.9 Major Office Surgery.

8.2.10 Mastectomy/Reconstructive Services.

In accordance with the Women's Health and Cancer Rights Act (WHCRA), SelectHealth covers mastectomies and reconstructive surgery after a mastectomy. If you are receiving Benefits in connection with a mastectomy, coverage for reconstructive surgery, including modifications or revisions, will be provided according to SelectHealth's Healthcare Management criteria and in a manner determined in consultation with you and the attending Physician, for:

a. All stages of reconstruction on the breast on which the mastectomy was performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Benefits are subject to the same Deductibles, Copays, and Coinsurance amounts applicable to other medical and surgical procedures covered by the Plan.

8.2.11 Medical/Surgical.

In an inpatient, outpatient, or Ambulatory Surgical Facility.

8.2.12 Physician Office Visits including Minor Surgery.

For consultation, diagnosis, and treatment.

8.2.13 Maternity Services.

Prenatal care, labor and delivery, and postnatal care, including complications of delivery.

8.2.14 Preventive Services.

8.2.15 Second Opinions.

Copay/Coinsurance/Deductible waived when requested by SelectHealth.

8.2.16 Sleep Studies.

Only when conducted by a designated sleep-study Participating Provider at a Participating Facility.

8.2.17 Sterilization Procedures.

8.3 Miscellaneous Services.

8.3.1 Adoption Indemnity Benefit.

SelectHealth provides an adoption indemnity Benefit to the extent required by Utah law. In order to receive this Benefit, the child must be placed with you for adoption within 90 days of the child's birth and the adoption must be finalized within one year of the child's birth. You must submit a claim for the Benefit within one year from the date of placement.

If you adopt more than one child from the same birth (e.g., twins), only one adoption indemnity Benefit applies. If you and/or your spouse are covered by multiple plans, SelectHealth will cover a prorated share of the adoption indemnity Benefit.

This Benefit is subject to Coinsurance, Copays, and Deductibles applicable to the maternity Benefit as indicated in your Member Payment Summary.

8.3.2 Allergy Tests,

Treatment, or Serum. Must be received from a board certified allergist, immunologist, or otolaryngologist. Oral food challenge testing only when administered by a Provider who is board certified in allergy/immunology.

8.3.3 Ambulance/Transportation Services.

Transport by a licensed service to the nearest Facility expected to have appropriate Services for the treatment of your condition. Only for Emergent Conditions and not when you could safely be transported by other means. Air ambulance transportation only when ground ambulance is either not available or, in the opinion of responding medical professionals, would cause an unreasonable risk of harm because of increased travel time. Transportation services in nonemergency situations must be approved in advance by SelectHealth.

8.3.4 Chemotherapy, Radiation Therapy, and Dialysis.

8.3.5 Cochlear Implants.

For prelingual deafness in children or postlingual deafness in adults in limited circumstances that satisfy SelectHealth criteria. Must be Preauthorized.

8.3.6 Durable Medical Equipment (DME).

Only when used in conjunction with an otherwise covered condition and must be:

a. prescribed by a Provider;

b. primarily used for medical purposes and not for convenience, personal comfort, or other nontherapeutic purposes; and

c. required for Activities of Daily Living.

SelectHealth will not provide payment for rental costs exceeding the purchase price. For covered rental DME that is subsequently purchased, cumulative rental costs are deducted from the purchase price.

8.3.7 Home Healthcare.

When you:

a. have a condition that requires the services of a licensed Provider;

b. are home bound for medical reasons;

c. are physically unable to obtain necessary medical care on an outpatient basis; and

d. are under the care of a Physician.

In order to be considered home bound, you must either:

e. have a medical condition that restricts your ability to leave the home without the assistance of another individual or supportive device or because absences from the home are medically contraindicated; or

f. leave the home only to receive medical treatment that cannot be provided in your home or other treatments that require equipment that cannot be made available in your home or infrequently and for short periods of time for nonmedical purposes.

You are not considered home bound if you leave the home regularly for social activities, drive a car, or do regular grocery or other shopping, work or business.

8.3.8 Hospice Care.

8.3.9 Injectable Drugs and Specialty Medications.

Up to a 30-day supply, though exceptions can be made for travel purposes. In general, your Physician will coordinate the process for obtaining these drugs. You may be required to receive the drug or medication in your Physician's office. Some Injectable Drugs and Specialty Medications may only be obtained from certain drug distributors. Call Member Services to determine if this is the case and to obtain information on participating drug vendors.

8.3.10 Miscellaneous Medical Supplies (MMS).

Only when prescribed by a Physician and not generally usable in the absence of an illness or injury.

8.3.11 Neuropsychological Testing (Medical).

As a medical Benefit, only as follows:

a. Testing performed as part of the preoperative evaluation for patients undergoing:

   i. seizure surgery

   ii. solid organ transplantation

   iii. central nervous system malignancy;

b. Patients being evaluated for dementia/AIzheimer's disease;

c. Stroke patients undergoing formal rehabilitation; and

d. Post-traumatic-brain-injury patients.

All other conditions are considered under the mental health Benefit, if applicable.

8.3.12 Organ Transplants.

a. Only if:

   i. Preauthorized in advance by SelectHealth; and

   ii. provided by Participating Providers in a Participating Facility unless otherwise approved in writing in advance by SelectHealth.

b. And only the following:

   i. bone marrow as outlined in SelectHealth criteria

   ii. combined heart/lung

   iii. combined pancreas/kidney

   iv. cornea

   v. heart

   vi. kidney (but only to the extent not covered by any government program)

   vii. liver

   viii. pancreas after kidney

   ix. single or double lung

For covered transplants, organ harvesting from donors is covered up to a limit specified in your Member Payment Summary. Services for both the donor and the recipient are only covered under the recipient's coverage.

Costs of a chartered service if transportation to a transplant site cannot be accomplished within four hours by commercial carrier.

8.3.13 Orthotics and Other Corrective Appliances for the Foot.

Not covered unless they are part of a lower foot brace, and they are prescribed as part of a specific treatment associated with recent, related surgery.

8.3.14 Osteoporosis Screening.

Only central bone density testing (DEXA scan).

8.3.15 Private Duty Nursing.

On a short-term, outpatient basis during a transition of care when ordered by a Physician. Not available for Respite Care or Custodial Care.

8.3.16 Rehabilitation Therapy.

Physical, occupational, and speech rehabilitative therapy when required to correct an impairment caused by a covered accident or illness or to restore an individual's ability to perform Activities of Daily Living.

8.3.17 Robotic-Assisted Surgery.

Only as set forth in SelectHealth medical criteria.

8.3.18 Temporomandibular Joint (TMJ).

8.3.19 Vision Aids.

Only:

a. Contacts for Members diagnosed with keratoconus, congenital cataracts, or when used as a bandage after eye trauma/injury.

b. Prescribed eyeglasses for Members following covered cataract surgery. In such cases, coverage is limited to a lifetime maximum of $100.

c. Monofocal intraocular lenses after cataract surgery.

8.4 Prescription Drug Services.

Refer to Section 9—Prescription Drug Benefits for details.

SECTION 9—PRESCRIPTION DRUG BENEFITS

This section includes important information about how to use your Prescription Drug Benefits. For additional information, refer to your Member Payment Summary and Section 10—Limitations and Exclusions. Note: this section does not apply to you if your Member Payment Summary indicates that your Plan does not provide Prescription Drug Benefits.

9.1 Use Participating Pharmacies.

To get the most from your Prescription Drug Benefits, use a Participating Pharmacy and present your ID card when filing a prescription. SelectHealth contracts with pharmacy chains on a national basis and with independent pharmacies in Utah.

If you use a Nonparticipating Pharmacy, you must pay full price for the drug and submit to SelectHealth a Prescription Reimbursement Form with your itemized pharmacy receipt. If the drug is covered, you will be reimbursed the Allowed Amount minus your Copay/Coinsurance and/or Deductible.

9.2 Tiered Benefits.

There are levels (or tiers) of covered prescriptions listed on your ID card and Member Payment Summary. This tiered Benefit allows you to choose the drugs that best meet your medical needs while encouraging you and your Provider to discuss treatment options and choose lower-tier drugs as therapeutically appropriate.

Drugs on each tier are selected by an expert panel of Physicians and pharmacists and may change periodically. To determine which tier a drug is assigned to, call Member Services or visit www.selecthealth.org/pharmacy.

9.3 Filling Your Prescription.

9.3.1 Copay/Coinsurance.

You generally will be charged one Copay/Coinsurance per covered prescription up to a 30-day supply at a retail pharmacy. If your Provider prescribes a dose of a medication that is not available, you will be charged a Copay for each strength of the medication.

9.3.2 Quantity and Day Supply.

Prescriptions are subject to SelectHealth quantity and day-supply Limitations. For example, controlled substances such as pain medications and stimulants are limited to a 30-day supply per prescription.

9.3.3 Refills.

Refills are allowed after 80 percent of the last refill has been used. Some exceptions may apply; call Member Services for more information.

9.4 Generic Drug Substitution Required.

Your Member Payment Summary will indicate if generic substitution is required. When generic substitution is required, the following guidelines apply:

a. A Generic Drug will be substituted for a brand-name drug unless your Provider indicates otherwise on the prescription.

b. If you request a brand-name drug instead of a Generic Drug, then you must pay the difference between the Allowed Amount for the Generic Drug and the Allowed Amount for the brand-name drug, plus your Copay/Coinsurance. The difference in cost between the Generic Drug and brand-name drug will not apply to your pharmacy Deductible and Out-of-Pocket Maximum.

c. If your Provider prescribes a brand-name drug for medical reasons, this penalty will not apply.

9.5 Maintenance Drugs.

SelectHealth offers a maintenance drug Benefit, allowing you to obtain a 90-day supply of certain medications. This Benefit is available for maintenance drugs you have been using for at least one month and expect to continue using for the next year. Maintenance drugs are identified by the letter (M) on the Prescription Drug List. You have two options when filling prescriptions under the maintenance drug Benefit: Retail90℠, which is available at certain retail pharmacies, and mail order. Please refer to your Member Payment Summary or contact Member Services to verify if the 90-day maintenance drug Benefit is available on your Plan.

9.6 Preauthorization of Prescription Drugs.

There are certain drugs that require Preauthorization by your Physician to be covered by SelectHealth. Prescription drugs that require Preauthorization are identified on the Prescription Drug List. The letters (PA) appear next to each drug that requires Preauthorization. Preauthorization is also required if the medication is in excess of the Plan limits (quantity, duration of use, maximum dose, etc.).

To obtain Preauthorization for these drugs, please have your Physician call SelectHealth Pharmacy Services at 801-442-4912 (Salt Lake area) or 800-442-3129, or visit www.selecthealth.org.

If your Physician prescribes a drug that requires Preauthorization, you should verify that Preauthorization has been obtained before purchasing the medication. You may still buy these drugs if they are not Preauthorized, but they will not be covered and you will have to pay the full price.

9.7 Step Therapy.

Certain drugs require your Provider to first prescribe an alternative drug preferred by SelectHealth. The alternative drug is generally a more cost-effective therapy that does not compromise clinical quality. If your Provider feels that the alternative drug does not meet your needs, SelectHealth may cover the drug without step therapy if SelectHealth determines it is Medically Necessary.

Prescription drugs that require step therapy are identified on the Prescription Drug List at the end of this section. The letters (ST) appear next to each drug that requires step therapy.

9.8 Prescription Drug Benefit Resources.

There are several resources you can use to obtain information about tiers, Participating Pharmacies, Preauthorization requirements, maintenance drugs, step therapy, generic substitutions, and your Prescription Drug Benefits. You can:

a. Visit www.selecthealth.org/pharmacy;

b. Refer to your Provider & Facility Directory;

c. Call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038, or visit www.selecthealth.org.

9.9 Coordination of Benefits.

If you have other health insurance that is your primary coverage, claims must be submitted first to your primary insurance carrier before being submitted to SelectHealth. In some circumstances, your secondary policy may pay a portion of your out-of-pocket expense. When you mail a secondary claim to SelectHealth, you must include a Prescription Reimbursement Form and the pharmacy receipt in order for SelectHealth to process your claim. In some circumstances, an Explanation of Benefits (EOB) from your primary carrier may also be required.

9.10 Inappropriate Prescription Practices.

In the interest of safety for our Members, SelectHealth reserves the right to not cover certain prescription medications. These medications include:

a. narcotic analgesics;

b. other addictive or potentially addictive medications; and

c. medications or drugs prescribed in quantities, dosages, or usages that are outside the usual standard of care for the medication in question.

These medications are not covered when they are prescribed:

d. outside the usual standard of care for the practitioner prescribing the medication;

e. in a manner inconsistent with accepted medical practice; or

f. for indications that are Experimental and/or Investigational.

This exclusion is subject to review by the SelectHealth Drug Utilization Panel and certification by a practicing clinician who is familiar with the medication and its appropriate use.

9.11 Prescription Drug Benefit Abuse.

SelectHealth may limit the availability and filling of any Prescription Drug that is susceptible to abuse. A care manager may require you to:

a. obtain prescriptions in limited dosages and supplies;

b. obtain prescriptions only from a specified Physician;

c. fill your prescriptions at a specified pharmacy;

d. participate in specified treatment for any underlying medical problem (such as a pain management program);

e. complete a drug treatment program; or

f. adhere to any other specified limitation or program designed to reduce or eliminate drug abuse or dependence.

If you seek to obtain drugs in amounts in excess of what is Medically Necessary, such as making repeated emergency room/urgent care visits to obtain drugs, SelectHealth may deny coverage of any medication susceptible of abuse.

SelectHealth may terminate you from coverage if you make an intentional misrepresentation of material fact in connection with obtaining or attempting to obtain drugs or medications, such as by intentionally misrepresenting your condition, other medications, healthcare encounters, or other medically relevant information. At SelectHealth's discretion, you may be permitted to retain your coverage if you comply with specified conditions.

9.12 Pharmacy Injectable Drugs and Specialty Medications.

While injectable drugs apply to your medical Benefits, some injectable drugs may also be covered under your Prescription Drug Benefits when filled at a pharmacy. For more specific information, please contact SelectHealth Member Services.

9.13 Prescription Drug List (PDL).

Refer to Appendix A—Prescription Drug List for the PDL.

9.14 Disclaimer.

SelectHealth refers to many of the drugs in this Certificate by their respective trademarks. SelectHealth does not own these trademarks. The manufacturer or supplier of each drug owns the drug's trademark. By listing these drugs, SelectHealth does not endorse or sponsor any drug, manufacturer, or supplier. Conversely, these manufacturers and suppliers do not endorse or sponsor any SelectHealth service or Plan, nor are they affiliated with SelectHealth.

SECTION 10—LIMITATIONS AND EXCLUSIONS

Unless otherwise noted in your Member Payment Summary or Appendix B—Benefit Riders, the following Limitations and Exclusions apply.

10.1 Abortions/Termination of Pregnancy.

Abortions are not covered except:

a. When determined by SelectHealth to be Medically Necessary to save the life or good health of the mother; or

b. Where the pregnancy was caused by a rape or incest if evidence of the rape or incest is presented either from medical records or through the review of a police report or the filing of charges that a crime has been committed; or

c. When there is evidence of grave fetal defects that are inconsistent with sustaining life.

Medical complications resulting from an abortion are covered. Treatment of a miscarriage/spontaneous abortion (occurring from natural causes) is covered.

10.2 Acupuncture/Acupressure.

Acupuncture and acupressure Services are not covered.

10.3 Administrative Services/Charges.

Services obtained for administrative purposes are not covered. Such administrative purposes include Services obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements.

Provider and Facility charges for completing insurance forms, duplication services, interest (except where required by Utah Administration Code R590-192), finance charges, late fees, shipping and handling, missed appointments, and other administrative charges are not covered.

10.4 Allergy Tests/Treatments.

The following allergy tests are not covered:

- Cytotoxic Test (Bryan's Test)
- Leukocyte Histamine Release Test
- Mediator Release Test (MRT)
- Passive Cutaneous Transfer Test (P-K Test)
- Provocative Conjunctival Test
- Provocative Nasal Test
- Rebuck Skin Window Test
- Rinkel Test
- Subcutaneous Provocative Food and Chemical Test
- Sublingual Provocative Food and Chemical Test

The following allergy treatments are not covered:

- Allergoids
- Autogenous urine immunization
- LEAP therapy
- Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.)
- Neutralization therapy
- Photo-inactivated extracts
- Polymerized extracts
- Oral desensitization/immunotherapy

10.5 Anesthesia.

General anesthesia rendered in a Provider's office is not covered.

10.6 Attention-Deficit/Hyperactivity Disorder.

Cognitive or behavioral therapies for the treatment of these disorders are not covered.

10.7 Bariatric Surgery.

Surgery to facilitate weight loss is not covered. The reversal or revision of such procedures and Services required for the treatment of complications from such procedures are not covered. However, medical or surgical complications that can be reasonably attributed to such a surgery will be considered for coverage if they arise ten years or more after the surgery. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Bariatric Surgery Benefit Rider.

10.8 Biofeedback/Neurofeedback.

Biofeedback/neurofeedback is not covered.

10.9 Birthing Centers and Home Childbirth.

Childbirth in any place other than a Hospital is not covered. This includes all Provider and/or Facility charges related to the delivery.

10.10 Certain Cancer Therapies.

The following cancer therapies are not covered:

- Neutron beam therapy
- Proton beam therapy

10.11 Certain Illegal Activities.

Services for an illness, condition, accident, or injury are not covered if it occurred:

a. While the Member was a voluntary participant in the commission of a felony;

b. While the Member was a voluntary participant in disorderly conduct, riot, or other breach of the peace;

c. While the Member was engaged in any conduct involving the illegal use or misuse of a firearm or other deadly weapon;

d. While the Member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle if the Member either:

i. Had sufficient alcohol in the Member's body that a subsequent test shows that the Member has either a blood or breath alcohol concentration of.08 grams or greater at the time of the test; or

ii. Had any illegal drug or other illegal substance in the Member's body to a degree that it affected the Member's ability to drive or operate the vehicle safely;

e. While the Member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor-driven vehicle either without a valid driver's permit or license, if required under the circumstances or without the permission of the owner of the vehicle; or

f. As a complication of, or as the result of, or as follow-up care for, any illness, condition, accident, or injury that is not covered as the result of this exclusion.

The presence of drugs or alcohol may be determined by tests performed by or for law enforcement, tests performed during diagnosis or treatment, or by other reliable means.

10.12 Chiropractic Services.

Chiropractic Services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Chiropractic Benefit Rider.

10.13 Claims After One Year.

Claims are denied if submitted more than one year after the Services were provided unless notice was given or proof of loss was filed as soon as reasonably possible. Adjustments or corrections to claims can be made only if the supporting information is submitted within one year after the claim was first processed by SelectHealth unless the additional information relating to the claim was filed as soon as reasonably possible.

When SelectHealth is the secondary payer, Coordination of Benefits will be performed only if the supporting information is submitted to SelectHealth within one year after the claim was processed by the primary plan unless the information was provided as soon as reasonably possible.

10.14 Complementary and Alternative Medicine (CAM).

Complementary, alternative and nontraditional Services are not covered. Such Services include acupuncture, homeopathy, homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography.

10.15 Complications.

All Services provided or ordered to treat complications of a non-Covered Service are not covered unless stated otherwise in this Certificate.

10.16 Custodial Care.

Custodial Care is not covered.

10.17 Dental Anesthesia.

Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at Participating Facilities when members meet the following criteria:

a. Member is developmentally delayed, regardless of the chronological age of the member; or

b. Member is under five years of age;

c. proposed dental work involves three or more teeth;

d. diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and

e. proposed procedures are restoration or extraction for rampant decay.

Consideration of coverage will be given to members, regardless of age, with congenital cardiac or neurological conditions who provide documentation that the need for dental anesthesia is due to their underlying medical condition and the need to closely monitor this condition.

10.18 Dry Needling.

Dry needling procedures are not covered.

10.19 Duplication of Coverage.

The following are not covered:

a. Services that are covered by, or would have been covered if you or your Dependents had enrolled and maintained coverage in:

i. Automobile insurance, including no-fault type coverage up to the minimum amount required by law. In the event of a claim, you should provide a copy of the Personal Injury Protection (PIP) documentation from the automobile insurance carrier; or

ii. Workers' Compensation.

b. Services for which you have obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation.

c. Services received by a Member incarcerated in a prison, jail, or other correctional facility at the time Services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration.

10.20 Experimental and/or Investigational Services.

Experimental and/or Investigational Services are not covered.

10.21 Eye Surgery,

Refractive. Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered.

10.22 Fitness Training.

Fitness training, conditioning, exercise equipment, and membership fees to a spa or health club are not covered.

10.23 Food Supplements.

Except for Dietary Products, as described in Section 8—Covered Services, food supplements and substitutes are not covered.

10.24 Gene Therapy.

Gene therapy or gene-based therapies are not covered.

10.25 Habilitation Therapy Services.

Services designed to create or establish function that was not previously present are not covered.

10.26 Hearing Aids.

Except for cochlear implants, as described in Section 8—Covered Services, the purchase, fitting, or ongoing evaluation of hearing aids, appliances, auditory brain implants, bone-anchored hearing aids, or any other procedure or device intended to establish or improve hearing or sound recognition is not covered.

10.27 Home Health Aides.

Services provided by a home health aide are not covered.

10.28 Immunizations.

The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.

10.29 Mental Health.

Inpatient and outpatient mental health and chemical dependency Services are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Mental Health/Chemical Dependency Benefit rider.

10.30 Methadone Therapy.

Methadone maintenance/therapy clinics or Services are not covered.

10.31 Non-Covered Service in Conjunction with a Covered Service.

When a non-Covered Service is performed as part of the same operation or process as a Covered Service, only charges relating to the Covered Service will be considered. Allowed Amounts may be calculated and fairly apportioned to exclude any charges related to the non-Covered Service.

10.32 Pain Management Services.

The following Services are not covered:

- Prolotherapy
- Radiofrequency ablation of dorsal root ganglion
- Acupuncture
- IV pamidronate therapy for the treatment of reflex sympathetic dystrophy

10.33 Pervasive Developmental Disorder.

Services for Pervasive Developmental Disorder are not covered.

10.34 Prescription Drugs/Injectable Drugs and Specialty Medications.

The following are not covered:

a. Appetite suppressants and weight loss medications;

b. Certain off-label drug usage, unless the use has been approved by a SelectHealth Medical Director or clinical pharmacist;

c. Compound drugs when alternative products are available commercially;

d. Cosmetic health and beauty aids;

e. Drugs purchased from Nonparticipating Providers over the Internet;

f. Flu symptom medications;

g. Drugs and medications purchased through a foreign pharmacy. However, please call Member Services if you have a special need for medications from a foreign pharmacy (for example, for an emergency while traveling out of the country);

h. Human growth hormone for the treatment of idiopathic short stature;

i. Infertility medications;

j. Medications not meeting the minimum levels of evidence based upon Food and Drug Administration (FDA) approval and/or DrugDex level IIa strength of recommendation, and National Comprehensive Cancer Network (NCCN) category 2A, if applicable.

k. Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;

l. Nicotine and smoking cessation medications, except in conjunction with a SelectHealth-sponsored smoking cessation program;

m. Over-the-counter (OTC) medications, except when all of the following conditions are met:

   i. The OTC medication is listed on the SelectHealth formulary as a covered medication;

   ii. The SelectHealth Pharmacy & Therapeutics Committee has approved the OTC medication as a medically appropriate substitution of

a Prescription Drug or medication; and

iii. The Member has obtained a prescription for the OTC medication from a licensed Provider and filled the prescription at a Participating Pharmacy;

n. Prescription Drugs used for cosmetic purposes;

o. Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;

p. Replacement of lost, stolen, or damaged drugs and medications;

q. Sexual dysfunction medications. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Benefit rider; and

r. Travel-related medications, including preventive medication for the purpose of travel to other countries. See Immunizations In Section 10—Limitations and Exclusions.

10.35 Reconstructive, Corrective, and Cosmetic Services.

Services provided for the following reasons are not covered:

a. to improve form or appearance;

b. to correct a deformity, whether congenital or acquired, without restoring physical function;

c. to cope with psychological factors such as poor self-image or difficult social relations;

d. as the result of an accident unless the Service is rendered within 12 months of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated within the 12-month period;

e. to revise a scar, whether acquired through injury or surgery, except when the primary purpose is to improve or correct a functional impairment.

The following procedures and the treatment for the following conditions are not covered, except as indicated:

f. Breast reduction (except according to SelectHealth criteria);

g. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair;

h. Port wine stain treatment (except according to SelectHealth criteria);

i. Sclerotherapy of superficial varicose veins (spider veins);

10.36 Rehabilitation Therapy Services.

The following are not covered:

a. Services for functional nervous disorders;

b. Vision rehabilitation therapy Services;

c. Speech therapy for developmental speech delay.

10.37 Related Provider Services.

Services provided to a Member by a Provider who ordinarily resides in the same household as the Member are not covered.

10.38 Respite Care.

Respite Care is not covered.

10.39 Sexual Dysfunction.

Services related to sexual dysfunction are not covered. This Exclusion does not apply if your Member Payment Summary indicates that your Plan includes the Sexual Dysfunction Benefit Rider.

10.40 Specialty Services.

Coverage for specific specialty Services may be restricted to only those Providers who are board certified or have other formal training that is considered necessary to perform those Services.

10.41 Specific Services.

The following Services are not covered:

- Anodyne infrared device for any indication
- Auditory brain implantation
- Chronic intermittent insulin IV therapy/ metabolic activation therapy
- Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue
- Computer-assisted interpretation of x-rays (except mammograms)
- Extracorporeal shock wave therapy for musculoskeletal indications
- Cryoablation therapy for plantar fasciitis and Morton's neuroma
- Freestanding/home cervical traction
- Home anticoagulation or hemoglobin A1C testing
- Infrared light coagulation for the treatment of hemorrhoids
- Interferential/neuromuscular stimulators
- Intimal Media Thickness (IMT) testing to assess risk of coronary disease
- Lovaas therapy
- Magnetic Source Imaging (MSI)
- Microprocessor controlled, computerized lower extremity limb prostheses
- Mole mapping
- Nonsurgical spinal decompression therapy (e.g., VAX-D or DRS therapy)
- Nucleoplasty or other forms of percutaneous disc decompression
- Pressure Specified Sensory Device (PSSD) for neuropathy testing

- Prolotherapy
- Radiofrequency ablation for lateral epicondylitis
- Radiofrequency ablation of the dorsal root ganglion
- Secretin infusion therapy for the treatment of autism
- Virtual colonoscopy
- Whole body scanning

10.42 Telephone/E-mail Consultations.

Charges for Provider telephone, e-mail, or other electronic consultations are not covered.

10.43 Terrorism or Nuclear Release.

Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.

10.44 Travel-related Expenses.

Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.

10.45 War.

Services for an illness, injury, or connected disability are not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any country.

SECTION 11—HEALTHCARE MANAGEMENT

SelectHealth works to manage costs while protecting the quality of care. The Healthcare Management Program reviews three aspects of medical care: appropriateness of the care setting, Medical Necessity, and appropriateness of Hospital lengths of stay. You benefit from this process because it reduces unnecessary medical expenses, enabling SelectHealth to maintain reasonable Premium rates. The Healthcare Management process takes several forms.

11.1 Preauthorization.

Preauthorization is prior approval from SelectHealth for certain Services and is considered a Preservice Claim (refer to Section—12 Claims and Appeals). Preauthorization is not required when SelectHealth is your secondary plan. However, it is required for injectable drugs and inpatient services when Medicare is your primary insurance. Obtaining Preauthorization does not guarantee coverage. Your Benefits for the Preauthorized Services are subject to the Eligibility requirements, Limitations, Exclusions and all other provisions of the Plan.

11.1.1 Services requiring Preauthorization.

Preauthorization is required for the following major Services:

a. All admissions to facilities, including rehabilitation, transitional care, skilled nursing, and all routine hospitalizations;

b. All nonroutine obstetrics admissions and maternity stays longer than two days for a normal delivery or longer than four days for a cesarean section;

c. Home health, hospice, outpatient private Nurse;

d. Pain management/pain clinic Services;

e. Selected Prescription Drugs (Refer to the Prescription Drug List in Appendix A—Prescription Drug Benefits);

f. The following Durable Medical Equipment:

   i. Insulin pumps and continuous glucose monitors;

   ii. Prosthetics (except eye prosthetics);

   iii. Negative pressure wound therapy electrical pump (wound vac);

   iv. Motorized or customized wheelchairs; and

   v. DME with a purchase price over $5,000.

g. The following Injectable Drugs and Specialty Medications*:

Actimmune
Apokyn
Araclyst
Avastin
Betaseron
Boniva
Botox
Cimzia
Erbitux
Euflexxa
Fabrazyme
Flolan
Forteo
Genotropin
Humatrope
Hyalgan
Hyaluronate
Immune Globulin
Increlex
Iplex
Ixempra
Kineret
Mecasermin
MyoBloc
Norditropin
Nplate
Nutropin AQ
Nutropin Depot
Nutropin
Orencia
Orthovisc
Pegasys
PEG-Intron
Pregnyl
Prialt
Profasi
Progesterone
Protropin
Reclast
Relistor
Remodulin
Saizen
Soliris
Somatrem

Somatropin
Somatropin (rDNA origin)
Somavert
Supartz
Synagis
Synvisc
Tev-Tropin
Torisel
Tysabri
Vectibix
Velcade
Ventavis
Xolair
Zorbtive

* This list is updated periodically. For the most current list, visit www.selecthealth.org/pharmacy or call Member Services.

11.1.2 Who is responsible for obtaining Preauthorization.

Participating Providers and Facilities are responsible for obtaining Preauthorization on your behalf; however, you should verify that they have obtained Preauthorization prior to receiving Services.

You are responsible for obtaining Preauthorization when using a Nonparticipating Provider or Facility, or when obtaining cochlear implants or organ transplants.

11.1.3 How to request Preauthorization.

If you need to request Preauthorization, call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.

You should call SelectHealth as soon as you know you will be using a Nonparticipating Provider or Facility for any of the Services listed. Preauthorization is valid for up to six months.

11.1.4 Penalties.

Failure to obtain Preauthorization of cochlear implants or organ transplants will result in the denial of Benefits.

11.1.5 Statement of Rights Under the Newborns' and Mothers' Health Protection Act.

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11.2 Case Management.

If you have certain serious or chronic conditions (such as spinal cord injuries, diabetes, asthma, or premature births), SelectHealth will work with you and your family, your Provider, and community resources to coordinate a comprehensive plan of care. This integrated approach helps you obtain appropriate care in cost-effective settings and reduces some of the burden that you and your family might otherwise face.

11.3 Benefit Exceptions.

On a case-by-case basis, SelectHealth may in its sole discretion extend or add Benefits that are not otherwise expressly covered or are limited by the Plan. In making this decision, SelectHealth will consider the medical appropriateness and cost effectiveness of the proposed exception.

When making such exceptions, SelectHealth reserves the right to specify the Providers, Facilities, and circumstances in which the additional care will be provided and to limit payment for additional Services to the amount SelectHealth would have paid had the Service been provided in accordance with the other provisions of the Plan. Benefits paid under this section are subject to all other Member payment obligations of the Plan such as Copays, Coinsurance, and Deductibles.

11.4 Second Opinions/Physical Examinations.

After enrollment, SelectHealth has the right to request that you be examined by a mutually agreed upon Provider concerning a claim, a second opinion request, or a request for Preauthorization. SelectHealth will be responsible for paying for any such physical examination.

11.5 Medical Policies.

SelectHealth has developed medical policies to serve as guidelines for coverage decisions. These guidelines detail when certain Services are considered Medically Necessary or Experimental and/or Investigational by SelectHealth. Medical policies generally apply to all of SelectHealth's fully insured Plans. Some Plans administered by SelectHealth, such as some self-funded employer plans or governmental plans, may not utilize SelectHealth's medical policies. Medical policies do not supersede the express provisions of the Certificate. Some Plans may not provide coverage for certain Services discussed in medical policies. Coverage decisions are subject to all terms and conditions of the applicable Plan, including specific Exclusions and Limitations. Because medical policies are based on constantly changing science, they are periodically reviewed and updated by SelectHealth.

SECTION 12—CLAIMS AND APPEALS

12.1 Administrative Consistency.

SelectHealth will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of the Plan and

that its provisions have been applied consistently with respect to similarly situated Claimants.

12.2 Claims and Appeals Definitions.

This section uses the following additional (capitalized) defined terms:

12.2.1 Adverse Benefit Determination.

Any of the following: a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's Eligibility, the application of a review under SelectHealth Healthcare Management Program, and determinations that particular Services are Experimental and/or Investigational or not Medically Necessary or appropriate.

12.2.2 Authorized Representative.

Someone you have designated to represent you in the claims or appeals process. To designate an Authorized Representative, you must provide written authorization on a form provided by the Appeals Department or Member Services. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this section, the words you and your include your Authorized Representative.

12.2.3 Benefit Determination.

The decision by SelectHealth regarding the acceptance or denial of a claim for Benefits.

12.2.4 Claimant.

Any Subscriber or Member making a claim for Benefits. Claimants may file claims themselves or may act through an Authorized Representative. In this section, the words you and your are used interchangeably with Claimant.

12.2.5 Concurrent Care Decisions.

Decisions by SelectHealth regarding coverage of an ongoing course of treatment that has been approved in advance.

12.2.6 Postservice Appeal.

A request to change an Adverse Benefit Determination for Services you have already received.

12.2.7 Postservice Claim.

Any claim related to Services you have already received.

12.2.8 Preservice Appeal.

A request to change an Adverse Benefit Determination on a Preservice Claim.

12.2.9 Preservice Claim.

Any claim that requires approval prior to obtaining Services for you to receive full Benefits. For example, a request for Preauthorization under the Healthcare Management program is a Preservice Claim.

12.2.10 Preservice Inquiry.

Your verbal or written inquiry to SelectHealth regarding the existence of coverage for proposed Services that do not involve a Preservice Claim, i.e., does not require prior approval for you to receive full Benefits. Preservice Inquiries are not claims and are not treated as Adverse Benefit Determinations.

12.2.11 Urgent Preservice Claim.

Any Preservice Claim that, if subject to the normal timeframes for determination, could seriously jeopardize your life, health or ability to regain maximum function or that, in the opinion of your treating Physician, would subject you to severe pain that could not be adequately managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of SelectHealth applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating Physician determines is an Urgent Preservice Claim will be treated as such.

12.3 How to Make a Preservice Inquiry.

Preservice Inquiries should be directed to Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038.A Preservice Inquiry is not a claim for Benefits.

12.4 How to File a Claim for Benefits.

12.4.1 Preservice Claims.

The procedure for filing most Preservice Claims (Preauthorization) is set forth in Section 11—Healthcare Management. If there is any other Benefit that would be subject to a Preservice Claim, you may file a claim for that Benefit by contacting Member Services. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a Preservice Claim, SelectHealth will provide notice of the failure and the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but no later than five days after receipt of the claim, and may be verbal unless you specifically request it in writing.

12.4.2 Urgent Preservice Claims.

In order to file an Urgent Preservice Claim, you must provide SelectHealth with:

a. information sufficient to determine to what extent Benefits are covered by the Plan; and

b. a description of the medical circumstances that give rise to the need for expedited review.

Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing an Urgent Preservice Claim, SelectHealth will notify you of the failure and the proper procedures to be followed. SelectHealth will notify you as soon as reasonably possible, but no later than 24 hours

after receiving the claim. This notice may be verbal unless you specifically request otherwise in writing.

12.4.3 Postservice Claims.

c. Participating Providers and Facilities. Participating Providers and Facilities file Postservice Claims with SelectHealth and SelectHealth makes payment to the Providers and Facilities.

d. Nonparticipating Providers and Facilities. Nonparticipating Providers and Facilities are not required to file claims with SelectHealth. If a Nonparticipating Provider or Facility does not submit a Postservice Claim to SelectHealth or you pay the Nonparticipating Provider or Facility, you must submit the claim in writing in a form approved by SelectHealth. Call Member Services or your employer to find out what information is needed to submit a Postservice Claim. All claims must be received by SelectHealth within a 36-month period from the date of the expense or as soon as reasonably possible. Claims received outside of this timeframe will be denied.

12.5 Timing of Benefit Determinations.

SelectHealth will make and notify you of its Benefit Determinations as follows:

12.5.1 Urgent Preservice Claims.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if SelectHealth gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. SelectHealth will provide a notice of Benefit Determination within 48 hours after receiving the specified information or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

If the Urgent Preservice Claim involves a Concurrent Care Decision, notice of the Benefit Determination will be provided as soon as possible but no later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

12.5.2 Other Preservice Claims.

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. However, SelectHealth may extend this period for up to an additional 15 days if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least 45 days from your receipt of the notice to provide the requested information.

Notice of an Adverse Benefit Determination regarding a Concurrent Care Decision will be provided sufficiently in advance of any termination or reduction of Benefits to allow you to appeal and obtain a determination before the Benefit is reduced or terminates.

12.5.3 Postservice Claims.

Notice of Adverse Benefit Determinations will be provided in writing within a reasonable period of time, but no later than 30 days after receipt of the claim. However, SelectHealth may extend this period for up to an additional 15 days if SelectHealth: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which SelectHealth expects to render a decision.

The applicable time period for the Benefit Determination begins when your claim is filed in accordance with SelectHealth's procedures, even if you have not submitted all the information necessary to make a Benefit Determination.

12.6 Notice of Adverse Benefit Determinations.

If your claim is subject to an Adverse Benefit Determination, you will receive a notification that includes:

a. The specific reason(s) for the Adverse Benefit Determination;

b. Reference to the specific provisions on which the Adverse Benefit Determination was based;

c. A description of any additional information or material needed from you to complete the claim and an explanation of why it is necessary;

d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other criterion will be provided upon request free of charge;

e. If the Adverse Benefit Determination was based on a Medical Necessity, Experimental and/or Investigational or similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;

f. If an Urgent Preservice Claim was denied, a description of the expedited review process applicable to the claim; and

g. A description of SelectHealth's review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under ERISA Section 502(a) with respect to any claim denied after an appeal.

12.7 Problem Solving.

SelectHealth is committed to making sure that all of your concerns or problems are investigated and resolved as soon as possible. Most situations can be resolved informally by a Member Services representative, usually within seven days. Call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038. SelectHealth offers foreign language assistance.

12.8 Formal Appeals.

If you are not satisfied with the result of working with Member Services, you may file a written formal appeal of any Adverse Benefit Determination or the negative outcome of a Preservice Inquiry. Written formal appeals should be sent to the SelectHealth Appeals Department. As the delegated claims review fiduciary under your Employer's Plan, SelectHealth will conduct a full and fair review of your appeal and has final discretionary authority and responsibility for deciding all matters regarding Eligibility and coverage.

12.8.1 General Rules and Procedures.

You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for Benefits. You will also have the opportunity to submit written comments, documents, records, and other information relating to your appeal. SelectHealth will consider this information regardless of whether it was considered in the Adverse Benefit Determination.

At each level in the appeal process, no deference will be afforded to the Adverse Benefit Determination, and decisions will be made by fiduciaries who did not make the Adverse Benefit Determination and who do not report to anyone who did. If the Adverse Benefit Determination was based on medical judgment, including determinations that Services are Experimental and/or Investigational or not Medically Necessary, the fiduciaries at each applicable level will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the Adverse Benefit Determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of SelectHealth in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

12.8.2 Form and Timing.

All requests for a formal appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want SelectHealth to review in conjunction with your appeal. Send all information to the SelectHealth Appeals Department at the following address:

Appeals Department
P.O. Box 30192
Salt Lake City, Utah 84130-0192

You may appeal an Adverse Benefit Determination of an Urgent Preservice Claim on an expedited basis either verbally or in writing. You may appeal verbally by calling the SelectHealth Appeals Department at 801-442-4684 (Salt Lake area) or 800-538-5038, ext.4684. If the request is made verbally, the SelectHealth Appeals Department will within 24 hours send written confirmation acknowledging the receipt of your request.

You may also formally appeal the negative outcome of a Preservice Inquiry by writing to the SelectHealth Appeals Department at the address above. You should include any information that you wish SelectHealth to review in conjunction with your appeal.

You must file a formal appeal within 180 days from the date you received notification of the Adverse Benefit Determination or made the Preservice Inquiry, as applicable.

Appeals that do not comply with the above requirements are not subject to review by SelectHealth or legal challenge.

12.8.3 Mandatory and Voluntary Appeal Levels.

As described below, the formal appeals process differs for Preservice Claims and Postservice Claims. In each case, there are both mandatory and voluntary levels of review. For purposes of the formal appeals process only, Preservice Inquiries will be treated like Preservice Claims.

You must exhaust all mandatory levels of review before you may pursue civil action under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary levels of review, and you are not required to do so before pursuing civil action. SelectHealth agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary appeal level is pending. Your decision whether or not to seek voluntary levels of review will have no effect on your rights to any other Benefits. SelectHealth will provide you, upon request, sufficient information

to enable you to make an informed decision about whether or not to engage in a voluntary level of review.

a. Preservice Appeals.

The formal process for Preservice Appeals and appealing the negative outcome of a Preservice Inquiry provides one mandatory review level, two possible voluntary review levels, and the right to pursue civil action under ERISA Section 502(a).

Step 1–Mandatory Review

Upon receipt, your appeal will be investigated by the Appeals Department. All relevant, available information will be reviewed by the Appeals Department, the Complaint Review Committee, or an appropriate healthcare practitioner. The Appeals Department will notify you in writing of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your appeal.

If your appeal involves an Urgent Preservice Claim, you may request an expedited review. You will be notified of the appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your appeal. A decision communicated verbally will be followed up in writing.

Step 2–First Level Voluntary Review

If you are dissatisfied with the decision made in Step 1, you may voluntarily request a review of your appeal by the SelectHealth Grievance Committee. If you are appealing an Adverse Benefit Determination regarding Medical Necessity, you may request a review of your appeal by either the Grievance Committee or an Independent Review Organization (IRO).You may appear in person or by telephone before the Grievance Committee to present any arguments or evidence you feel is relevant to the matter; however, participation is not a requirement. An IRO is an independent, external review organization that is not connected in any way with SelectHealth. The IRO engages healthcare professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for the Grievance Committee or IRO appeal. Such a request for this voluntary review must be made in writing to the Appeals Department within 60 days for Grievance Committee review (180 days for an IRO review) from the date the Appeals Department notifies you of the appeal decision. If you are appealing an Adverse Benefit Determination of Medical Necessity, your request must specify whether the appeal is to the Grievance Committee or to an IRO. SelectHealth will notify you of the result of the Grievance Committee or IRO review in writing within 30 days of the date you requested the review.

If your appeal involves an Urgent Preservice Claim, you may verbally request an expedited review. You will be notified of the appeal decision on an expedited review as soon as possible, taking into account the medical circumstances, but no later than 72 hours after the receipt of your appeal. A decision communicated verbally will be followed up in writing.

Step 3-Second Level Voluntary Review

If you are dissatisfied with the result of Step 2, and you do not require an expedited review, you may voluntarily request to have your appeal reviewed by the SelectHealth Appeals Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date of SelectHealth's response to Step 2.You may appear in person or by telephone before the Appeals Committee to present any arguments or evidence you feel is relevant to the matter; however, participation is not a requirement. SelectHealth will notify you of the result of the Appeals Committee review in writing within 60 days of the date you requested the review.

Note: This level of review is not available on an expedited basis. There is only one level of voluntary review (Step 2) for Urgent Preservice Claims that requires expedited review.

The Appeals Committee may, in its sole discretion and at no cost to you, seek an assessment from an IRO in conjunction with its decision if no such review has previously been conducted.

Civil Action

At any point after the mandatory review process (Step 1), you may choose to pursue civil action under ERISA Section 502(a).Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge SelectHealth's original decision.

b. Postservice Appeals.

The formal process for Postservice Appeals provides two mandatory review levels, one voluntary review level, and the right to pursue civil action under ERISA Section 502(a).

Step 1–First Level Mandatory Review

Upon receipt, your appeal will be investigated by the SelectHealth Appeals Department. All relevant information will be reviewed by the Appeals Department, the Complaint Review Committee, or an appropriate healthcare practitioner..The Appeals Department will notify you in writing of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after the receipt of your appeal.

Step 2–Second Level Mandatory Review

If you are dissatisfied with the decision made in Step 1, you may request further consideration by the SelectHealth Grievance Committee. Such a request must be made in writing to the Appeals Department within 60 days of the date the Appeals Department notifies you of its appeal decision. You may appear in person or by telephone before the Grievance Committee to present any arguments or evidence you feel are relevant to the matter; however, participation is not a requirement. SelectHealth will notify you of the result of the Grievance Committee review in writing within 30 days of the date you requested the review.

The Grievance Committee may, in its sole discretion and at no cost to you, seek an assessment from an IRO in conjunction with its decision if no such review has previously been conducted.

Step 3–Voluntary Appeals Committee Review

If you are dissatisfied with the result of Step 2, you may voluntarily request a review of your appeal by the SelectHealth Appeals Committee. If you are appealing an Adverse Benefit Determination regarding Medical Necessity, you may request a review of your appeal by either the Appeals Committee or an IRO. You may appear in person or by telephone before the Appeals Committee to present any arguments or evidence you feel is relevant to the matter; however, participation is not a requirement. An IRO is an independent external review organization that is not connected in any way with SelectHealth. The IRO engages healthcare professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for the Appeals Committee or IRO review. Your request for voluntary review must be made in writing to the Appeals Department within 60 days for Appeals Committee review, and for an IRO review within 180 days from the date of SelectHealth's response to the second level mandatory review. If you are appealing an Adverse Benefit Determination of Medical Necessity, your request must specify whether the appeal is to the Appeals Committee or to an IRO. SelectHealth will notify you of the result of the Appeals Committee or IRO review in writing within 60 days of the date you requested the review.

The Appeals Committee may, in its sole discretion and at no cost to you, seek an assessment from an IRO in conjunction with its decision if no such review has previously been conducted.

Civil Action

At any point after SelectHealth's mandatory review process (Steps 1 and 2), you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge SelectHealth's original decision.

12.8.4 Notification of Appeal Decisions.

At each applicable level of the appeals process described above, if your appeal is denied SelectHealth's written notification will include the following information:

a. A statement of SelectHealth's understanding of the pertinent facts of the appeal;

b. The specific reason(s) for the adverse determination, in easily understandable language;

c. Reference to the specific provisions on which the adverse determination was based;

d. A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the claim;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided upon request free of charge;

f. If the denied appeal was based on a Medical Necessity, Experimental and/or Investigational or similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;

g. A list of titles and qualifications of the individuals participating in the review; and

h. A statement describing any additional mandatory or voluntary appeal levels either required or offered by SelectHealth, including the opportunity for IRO assessment, if applicable, your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA Section 502(a).

i. Notification of the decision on an Urgent Preservice Claim may be provided verbally, but a follow-up written notification will be provided no later than three days after the verbal notice.

12.8.5 Physical Examinations/Second Opinions.

SelectHealth has the right to request that a Member be examined by an appropriate Provider chosen by SelectHealth in conjunction with an appeal. SelectHealth will pay for any such exam.

SECTION 13—OTHER PROVISIONS AFFECTING YOUR BENEFITS

13.1 Coordination of Benefits.

When you or your Dependents have healthcare coverage under more than one health benefit plan, SelectHealth will coordinate Benefits with the other healthcare coverage according to the Coordination of Benefits rules set forth in Utah Code, Section 31A-22-619.

13.1.1 Required Cooperation.

You are required to cooperate with SelectHealth in administering Coordination of Benefits. Cooperation may include providing notice of other health benefit coverage, copies of divorce decrees, bills and payment notices from other payers, and/or signing documents required by SelectHealth to administer Coordination of Benefits. Failure to cooperate may result in the denial of claims.

13.1.2 Direct Payments.

SelectHealth may make a direct payment to another health benefit plan when the other plan has made a payment that was SelectHealth's responsibility. This amount will be treated as though it was a Benefit paid by the Plan, and SelectHealth will not have to pay that amount again.

13.2 Subrogation/Restitution.

As a condition to receiving Benefits under the Plan, you and your Dependents (hereinafter you) agree that SelectHealth is automatically subrogated to, and has a right to receive equitable restitution from, any right of recovery you may have against any third party as the result of an accident, illness, injury, or other condition involving the third party (hereinafter third-party event) that causes you to obtain Covered Services that are paid for by SelectHealth. SelectHealth is entitled to receive as equitable restitution the proceeds of any judgment, settlement, or other payment paid or payable in satisfaction of any claim or potential claim that you have or could assert against the third party to the extent of all Benefits paid by SelectHealth or payable in the future by SelectHealth because of the third-party event.

Any funds you (or your agent or attorney) recover by way of settlement, judgment, or other award from a third party or from your own insurance due to a third-party event as described in this section shall be held by you (or your agent or attorney) in a constructive trust for the benefit of SelectHealth until SelectHealth's equitable restitution interest has been satisfied.

SelectHealth shall have the right to intervene in any lawsuit, threatened lawsuit, or settlement negotiation involving a third party for purposes of asserting and collecting its equitable restitution interest as described in this section. SelectHealth shall have the right to bring a lawsuit against, or assert a counterclaim or cross-claim against, you (or your agent or attorney) for purposes of collecting SelectHealth's equitable restitution interest or to enforce the constructive trust required by this section.

Except for proceeds obtained from uninsured or underinsured motorist coverage, this contractual right of subrogation/restitution applies whether or not you believe that you have been made whole or otherwise fully compensated by any recovery or potential recovery from the third party and regardless of how the recovery may be characterized, e.g., as compensation for damages other than medical expenses.

You are required to:

a. promptly notify SelectHealth of all possible subrogation/restitution situations;

b. help SelectHealth or its designated agent to assert its subrogation/restitution interest;

c. not take any action that prejudices SelectHealth's right of subrogation/restitution, including settling a dispute with a third party without protecting SelectHealth's subrogation/restitution interest;

d. sign any papers required to enable SelectHealth to assert its subrogation/restitution interest.

e. grant to SelectHealth a first priority lien against the proceeds of any settlement, verdict, or other amounts you receive; and

f. assign to SelectHealth any benefits you may have under any other coverage to the extent of SelectHealth's claim for restitution.

SelectHealth's right of subrogation/restitution exists to the full extent of any payments made, Services provided, or expenses incurred on your behalf because of or reasonably related to the third-party event.

You (or your agent or attorney) will be personally liable for the equitable restitution amount to the extent that SelectHealth does not recover that amount through the process described above.

If you fail to fully cooperate with SelectHealth or its designated agent in asserting SelectHealth's subrogation/restitution right, then limited to the compensation you (or your agent or attorney) have received from a third party, SelectHealth may reduce or deny coverage under the Plan and offset against any future claims. Further, SelectHealth may compromise with you on any issue involving subrogation/restitution in a way that includes your surrendering the right to receive further Services under the Plan for the third-party event.

SelectHealth will reduce the equitable restitution required in this section to reflect reasonable costs or attorneys' fees incurred in obtaining compensation, as separately agreed to in writing between SelectHealth and your attorney.

13.3 Right of Recovery.

SelectHealth will have the right to recover any payment made in excess of SelectHealth's obligations under the Contract. Such recoveries are limited to a time period of 12 months (or 24 months for a Coordination of Benefits error) from the date a payment is made unless the recovery is due to fraud or intentional material misrepresentation by you or your Dependents. This right of recovery will apply to payments made to you, your Dependents, your employer, Providers, or Facilities. If an excess payment is made by SelectHealth to you, you agree to promptly refund the amount of the excess. SelectHealth may, at its sole discretion, offset any future Benefits against any overpayment.

SECTION 14—SUBSCRIBER RESPONSIBILITIES

As a condition to receiving Benefits, you are required to pay:

14.1 Payment.

Pay applicable Premiums to your employer, and pay the Coinsurance, Copay, and/or Deductible amounts listed in your Member Payment Summary to your Provider(s) and/or Facilities.

14.2 Changes in Eligibility or Contact Information.

Notify your employer when there is a change in your situation that may affect your Eligibility, the Eligibility of your Dependents, or if your contact information changes. Your employer has agreed to notify us of these changes.

14.3 Other Coverage.

Notify SelectHealth if you or your Dependents obtain other healthcare coverage. This information is necessary to accurately process and coordinate your claims.

14.4 Information/Records.

Provide us all information necessary to administer your coverage, including the medical history and records for you and your Dependents and, if requested, your social security number(s).

14.5 Notification of Members.

Notify your enrolled Dependents of all Benefit and other Plan changes.

SECTION 15—EMPLOYER RESPONSIBILITIES

15.1 Enrollment.

Your employer makes initial Eligibility decisions and communicates them to SelectHealth. SelectHealth reserves the right to verify that the Eligibility requirements of the Contract are satisfied. Your employer is obligated to promptly notify us whenever there is a change in your situation that may affect your Eligibility or the Eligibility of your Dependents. This includes FMLA and other leaves of absence.

15.2 Payment.

All enrollments are conditioned upon the timely payment of Premiums to SelectHealth by your employer.

15.3 Contract.

The Contract is with your employer, and only your employer can change or terminate it. Your employer is responsible for notifying you of any changes to the Plan and for providing you at least 30 days written notice if the Contract is terminated for any reason.

15.4 Compliance.

Your employer is responsible for complying with all reporting, disclosure, and other requirements for your Employer's Plan under federal law.

SECTION 16—DEFINITIONS

This Certificate of Coverage contains certain defined terms that are capitalized in the text and described in this section. Words that are not defined have their usual meaning in everyday language.

16.1 Activities of Daily Living.

Eating, personal hygiene, dressing, and similar activities that prepare an individual to participate in work or school. Activities of Daily Living do not include recreational, professional, or school-related sporting activities.

16.2 Allowed Amount.

The dollar amount allowed by SelectHealth for a specific Covered Service.

16.3 Ambulatory Surgical Facility.

A Facility licensed by the state where Services are provided to render surgical treatment and recovery on an outpatient basis to sick or injured persons under the direction of a Physician. Such a Facility does not provide inpatient Services.

16.4 Annual Open Enrollment.

The period of time each year specified in by your employer during which you are given the opportunity to enroll yourself and your Dependents in the Plan.

16.5 Benefit Rider.

Additional coverage purchased by your employer as noted in your Member Payment Summary that modifies Limitations and/or Exclusions.

16.6 Benefit(s).

The payments and privileges to which you are entitled by this Certificate and the Contract.

16.7 Certificate of Coverage (Certificate).

This document, which describes the terms and conditions of the health insurance Benefits provided

by your employer's Group Health Insurance Contract with SelectHealth. Your Member Payment Summary is attached to and considered part of this Certificate.

16.8 COBRA Coverage.

Coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

16.9 Coinsurance.

A percentage of the Allowed Amount stated in your Member Payment Summary that you must pay for Covered Services to the Provider and/or Facility.

16.10 Continuation Coverage.

COBRA Coverage and/or Utah mini-COBRA Coverage.

16.11 Contract.

The Group Health Insurance Contract between SelectHealth and your employer.

16.12 Conversion Coverage.

A separate, individual policy you may have the right under Utah law to obtain after your coverage under the group Contract is terminated.

16.13 Copay (Copayment).

A fixed amount stated in your Member Payment Summary that you must pay for Covered Services to a Provider or Facility.

16.14 Covered Services.

The Services listed in Section 8—Covered Services and applicable Benefit Riders and not excluded in Section 10—Limitations and Exclusions.

16.15 Custodial Care.

Services provided primarily to maintain rather than improve a Member's condition or for the purpose of controlling or changing the Member's environment. Services requested for the convenience of the Member or the Member's family that do not require the training and technical skills of a licensed Nurse or other licensed Provider, such as convalescent care, rest cures, nursing home services, etc. Services that are provided principally for personal hygiene or for assistance in daily activities.

16.16 Deductible(s).

An amount stated in your Member Payment Summary that you must pay each Year for Covered Services before SelectHealth makes any payment. Some categories of Benefits may be subject to separate Deductibles.

16.17 Dental Services.

Services rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth.

16.18 Dependents.

Your lawful spouse and any child who meets the Eligibility criteria set forth in Section 2—Eligibility and the Group Application.

16.19 Diagnostic Tests, Major.

Diagnostic tests categorized as major by SelectHealth. SelectHealth categorizes tests based on several considerations such as the invasiveness and complexity of the test, the level of expertise required to interpret or perform the test, and where the test is commonly performed. Examples of common Major Diagnostic Tests are:

a. imaging studies such as MRIs, CT scans, and PET scans

b. neurologic studies such as EMGs and nerve conduction studies

c. cardiovascular procedures such as coronary angiograms

d. gastrointestinal procedures such as EGDs, ERCPs, and colonoscopies

e. gene-based testing and genetic testing

If you have a question about the category of a particular test, please contact SelectHealth Member Services.

16.20 Diagnostic Tests, Minor.

Tests not categorized as Major Diagnostic Tests are considered Minor Diagnostic Tests. Examples of common Minor Diagnostic Tests are:

a. bone density tests

b. certain EKGs

c. echocardiograms

d. routine blood and urine tests

e. simple x-rays such as chest and long bone x-rays

f. spirometry/pulmonary function testing

16.21 Durable Medical Equipment (DME).

Medical equipment that is able to withstand repeated use and is generally not useful in the absence of an illness or injury.

16.22 Effective Date.

The date on which coverage for you and/or your Dependents begins.

16.23 Eligible, Eligibility.

In order to be Eligible, you or your Dependents must meet the criteria for participation specified in Section 2—Eligibility and in the Group Application.

16.24 Emergent Condition(s).

A condition of recent onset and sufficient severity, including severe pain, that would lead a prudent

layperson, possessing an average knowledge of medicine and health, to reasonably expect that failure to obtain immediate medical care could result in:

a. placing the Member's health in serious jeopardy;

b. placing the health of a pregnant woman or her unborn child in serious jeopardy;

c. serious impairment to bodily functions; or

d. serious dysfunction of any bodily organ or part.

16.25 Employer Waiting Period.

The period that you must wait after becoming Eligible for coverage before your Effective Date. Subject to approval by SelectHealth, your employer specifies the length of this period in the Group Application.

16.26 Employer's Plan.

The group health plan sponsored by your employer and insured under the Contract.

16.27 Endorsement.

A document that amends the Contract.

16.28 ERISA.

The Employee Retirement Income Security Act (ERISA), a federal law governing employee benefit plans.

16.29 Excess Charges.

Charges from Providers and Facilities that exceed SelectHealth's Allowed Amount for Covered Services. You are responsible to pay for Excess Charges from Nonparticipating Providers and Facilities. These charges do not apply to your Out-of-Pocket Maximum.

16.30 Exclusion(s).

Situations and Services that are not covered by SelectHealth under the Plan. Most Exclusions are set forth in Section 10—Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of excluding coverage in particular situations.

16.31 Experimental and/or Investigational.

A Service for which one or more of the following apply:

a. It cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;

b. It is the subject of a current investigational new drug or new device application on file with the FDA;

c. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial;

d. It is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); or

e. If the predominant opinion among appropriate experts as expressed in the peer-reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the Service.

16.32 Facility.

An institution that provides certain healthcare Services within specific licensure requirements.

16.33 Generic Drug(s).

A medication that has the same active ingredients, safety, dosage, quality, and strength as its brand-name counterpart. Both the brand-name drug and the Generic Drug must get approval from the FDA before they can be sold.

16.34 Group Application.

A form used by SelectHealth both as an application for coverage by your employer and to specify group-specific details of coverage. The Group Application may contain modifications to the language of the Contract. It also demonstrates your employer's acceptance of the Contract. Other documents, such as Endorsements, may be incorporated by reference into the Group Application.

16.35 Group Health Insurance Contract.

The agreement between your employer and SelectHealth that contains the terms and conditions under which SelectHealth provides group insurance coverage to you and your Dependents. The Group Application and this Certificate are part of the Group Health Insurance Contract.

16.36 Healthcare Management Program.

A program designed to help you obtain quality, cost-effective, and medically appropriate care, as described in Section 11—Healthcare Management.

16.37 Home Healthcare.

Services provided to Members at their home by a licensed Provider who works for an organization that is licensed by the state where Services are provided.

16.38 Hospice Care.

Supportive care provided on an inpatient or outpatient basis to a terminally ill Member not expected to live more than six months. May also be provided to the Member's immediate family at the family's expense.

16.39 Hospital.

A Facility that is licensed by the state in which Services are provided that is legally operated for the medical care and treatment of sick or injured individuals.

A Facility that is licensed and operating within the scope of such license, which:

a. operates primarily for the admission, acute care, and treatment of injured or sick persons as inpatients;

b. has a 24-hour-a-day nursing service by or under the supervision of a graduate registered Nurse (R.N.) or a licensed practical Nurse (L.P.N.);

c. has a staff of one or more licensed Physicians available at all times; and

d. provides organized facilities for diagnosis and surgery either on its premises or in facilities available to the Hospital on a contractual prearranged basis.

16.40 Infertility.

The inability to become pregnant or impregnate.

16.41 Injectable Drugs and Specialty Medications.

A class of drugs that may be administered orally, as a single injection, intravenous infusion or in an inhaled/nebulizer solution. Injectable drugs and specialty medications include all or some of the following:

a. Are often products of a living organism or produced by a living organism through genetic manipulation of the organism's natural function

b. Are generally used to treat an ongoing chronic illness

c. Require special training to administer

d. Have special storage and handling requirements

e. Are typically limited in their supply and distribution to patients or Providers

f. Often have additional monitoring requirements

Certain drugs used routinely in a Provider's office to treat common medical conditions (such as intramuscular penicillin) are not considered Injectable Drugs and Specialty Medications, because they are widely available, distributed without limitation, and are not the product of bioengineering.

16.42 Initial Eligibility Period.

The period determined by SelectHealth and your employer during which you may enroll yourself and your Dependents in the Plan. The Initial Eligibility Period is identified in the Group Application.

16.43 Lifetime Maximum.

The maximum accumulated amount that SelectHealth will pay for Covered Services rendered to a Member during that Member's lifetime. This includes all amounts paid on behalf of the Member under any prior health benefit plans insured by SelectHealth (including those sponsored by former employers) or any of its affiliated or subsidiary companies. In addition, some categories of Benefits are subject to a separate Lifetime Maximum. Lifetime Maximums are specified in your Member Payment Summary.

16.44 Limitation(s).

Situations and Services in which coverage is limited by SelectHealth under the Plan. Most Limitations are set forth in Section 10—Limitations and Exclusions, but other provisions throughout this Certificate and the Contract may have the effect of limiting coverage in particular situations.

16.45 Limiting Age.

The maximum age for Dependent coverage, as set forth in the Group Application.

16.46 Medical Director.

The Physician(s) designated as such by SelectHealth.

16.47 Medical Necessity/Medically Necessary.

Services that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

a. in accordance with generally accepted standards of medical practice in the United States;

b. clinically appropriate in terms of type, frequency, extent, site, and duration; and

c. not primarily for the convenience of the patient, Physician, or other Provider.

When a medical question-of-fact exists, Medical Necessity shall include the most appropriate available supply or level of service for the Member in question, considering potential benefit and harm to the Member.

Medical Necessity is determined by the treating Physician and by SelectHealth's Medical Director or his or her designee. The fact that a Provider or Facility, even a Participating Provider or Facility, may prescribe, order, recommend, or approve a Service does not make it Medically Necessary, even if it is not listed as an Exclusion or Limitation.FDA approval, or other regulatory approval, does not establish Medical Necessity.

16.48 Member.

You and your Dependents, when properly enrolled in the Plan and accepted by SelectHealth.

16.49 Member Payment Summary.

A summary of your Benefits by category of service, attached to and considered part of this Certificate.

16.50 Miscellaneous Medical Supplies (MMS).

Supplies that are disposable or designed for temporary use.

16.51 Nonparticipating (Out-of-Network) Facility.

Healthcare Facilities that are not under contract with SelectHealth.

16.52 Nonparticipating (Out-of-Network) Pharmacies.

Pharmacies that are not under contract with SelectHealth.

16.53 Nonparticipating (Out-of-Network) Provider.

Providers that are not under contract with SelectHealth.

16.54 Nurse.

A graduate Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is licensed by the state where Services are provided to provide medical care and treatment under the supervision of a Physician.

16.55 Office Surgery, Major.

Surgical and endoscopic procedures in a Provider's office for which SelectHealth's Allowed Amount is more than the dollar threshold indicated in your Member Payment Summary.

16.56 Office Surgery, Minor.

Surgical and endoscopic procedures in a Provider's office for which SelectHealth's Allowed Amount is less than the dollar threshold indicated in your Member Payment Summary.

16.57 Out-of-Pocket Maximum.

The maximum amount specified in your Member Payment Summary that you must pay each Year to Providers and/or Facilities as Deductibles, Copays, and Coinsurance. Except when otherwise noted in your Member Payment Summary, SelectHealth will pay 100 percent of Allowed Amounts during the remainder of the Year once the Out-of-Pocket Maximum is satisfied. Some categories of Benefits may be subject to separate Out-of-Pocket Maximums. Payments you make for Excess Charges, non-Covered Services, and any other categories of Services specified in your Member Payment Summary are not applied to the Out-of-Pocket Maximum.

16.58 Participating (In-Network) Benefits.

Benefits available to you when you obtain Covered Services from a Participating Provider or Facility.

16.59 Participating (In-Network) Facility.

Facilities under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.60 Participating (In-Network) Pharmacies.

Pharmacies under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.61 Participating (In-Network) Providers.

Providers under contract with SelectHealth to accept Allowed Amounts as payment in full for Covered Services.

16.62 Pervasive Developmental Disorder (PDD/Developmental Delay).

A state in which an individual has not reached certain developmental milestones normal for that individual's age, yet no obvious medical diagnosis or condition has been identified that could explain the cause of this delay. PDD includes five disorders characterized by delays in the development of multiple basic functions, including socialization and communication.PDD includes:

- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Syndrome
- Pervasive developmental disorder not otherwise specified.

16.63 Physician.

A doctor of medicine or osteopathy who is licensed by the state in which he or she provides Services and who practices within the scope of his or her license.

16.64 Plan.

The specific combination of Covered Services, Limitations, Exclusions, and other requirements agreed upon between SelectHealth and your employer as set forth in this Certificate and the Contract.

16.65 Plan Sponsor.

As defined in ERISA. The Plan Sponsor is typically your employer.

16.66 Preauthorization.

Prior approval from SelectHealth for certain Services. Refer to Section 11—Healthcare Management and your Member Payment Summary.

16.67 Premium(s).

The amount your Employer periodically pays to SelectHealth as consideration for providing Benefits under the Plan. The Premium is specified in the Group Application.

16.68 Prescription Drugs.

Drugs and medications, including insulin, that by law must be dispensed by a licensed pharmacist or Physician and that require a Physician's written prescription.

16.69 Preventive Services.

Certain examinations, procedures, immunizations, screenings, x-rays, and laboratory tests that can detect disease conditions not known to currently exist, or which, in the case of immunizations, prevent the development of disease.

16.70 Primary Care Physician or Primary Care Provider (PCP).

A general practitioner who attends to common medical problems, provides Preventive Services, and health maintenance. The following types of Physicians and Providers, and their associated physician assistants and nurse practitioners, are PCPs:

- Certified Nurse Midwives
- Family Practice
- Geriatrics
- Internal Medicine
- Obstetrics and Gynecology (OB/GYN)
- Pediatrics

16.71 Private Duty Nursing.

Services rendered by a Nurse to prepare and educate family members and other caregivers on proper procedures for care during the transition from an acute Hospital setting to the home setting. These Services must improve, rather than maintain, your health condition and require the skills of a Nurse in order to be provided safely and effectively.

16.72 Provider.

A vendor of healthcare Services licensed by the state where Services are provided and that provides Services within the scope of its license.

16.73 Qualified Medical Child Support Order.

A court order for the medical support of a child as defined in ERISA.

16.74 Respite Care.

Care provided primarily for relief or rest from caretaking responsibilities.

16.75 Secondary Care Physician or Secondary Care Provider (SCP).

Physicians and other Providers who are not a Primary Care Physician or Primary Care Provider. Examples of an SCP include:

- Cardiologists
- Dermatologists
- Neurologists
- Ophthalmologists
- Orthopedic Surgeons
- Otolaryngologists (ENTs)

16.76 Service Area.

The geographical area in which SelectHealth arranges for Covered Services for Members from Participating Providers and Facilities. Contact SelectHealth for Service Area information if the U.S. Postal Service changes or adds ZIP codes after the beginning of the Year.

Select Care Service Area. The following counties: Beaver, Box Elder, Cache, Davis, Duchesne, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber. However, not all ZIP codes within these counties are included. The following ZIP codes are not part of the Select Care Service Area: 84034, 84083, 84313, and 84329.

Select Med Service Area. The following counties: Beaver, Box Elder, Cache, Davis, Duchesne, Garfield, Iron, Juab, Millard, Morgan, Piute, Salt Lake, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne, and Weber. However, not all ZIP codes within these counties are included. The following ZIP codes are not part of the Select Med Service Area: 84008, 84034, 84035, 84078, 84079, 84083, 84313, 84329, 84712, 84716, 84717, 84718, 84723,84734, 84736, 84759, 84764, and 84776.

Select Value Service Area. The following counties: Davis, Salt Lake, Summit, Utah, and Weber. However, not all ZIP codes within these counties are included. As of January 2006, the following ZIP codes are not part of the Select Value Service Area: 84017, 84024, 84033, 84036, 84055, 84061, 84013, 84626, 84651, 84653, 84655, 84660, and 84633.

16.77 Service(s).

Services, care, tests, treatments, drugs, medications, supplies, or equipment.

16.78 Skilled Nursing Facility.

A Facility that provides Services that improve, rather than maintain, your health condition, that requires the skills of a Nurse in order to be provided safely and effectively, and that:

a. Is being operated as required by law;

b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a Physician;

c. Provides 24 hours a day, seven days a week nursing service by or under the supervision of a Registered Nurse (R.N.); and

d. Maintains a daily medical record of each patient.

A Skilled Nursing Facility is not a place that is primarily used for rest or for the care and treatment of mental diseases or disorders, Chemical Dependency, alcoholism, Custodial Care, nursing home care, or educational care.

16.79 Special Enrollment Right.

An opportunity to enroll in the Plan outside of your employer's Annual Open Enrollment period under defined circumstances described in Section 3—Enrollment.

16.80 Subscriber.

You, the individual with an employment or another defined relationship to the Plan Sponsor, through whom Dependents may be enrolled with SelectHealth.

16.81 Subscriber Application.

The form on which you apply for coverage under the Plan.

16.82 Urgent Condition(s).

An acute health condition with a sudden, unexpected onset that is not life threatening but that poses a danger to a person's health if not attended by a Physician within 24 hours, e.g., high fevers, possible fractures.

16.83 Utah mini-COBRA.

Continuation coverage required by Utah law for employers with fewer than 20 employees.

16.84 Year.

Benefits are calculated on either a calendar-year or plan-year basis, as indicated on your Member Payment Summary.

a. The calendar year begins on January 1 at 12:00 a.m. Mountain Standard Time and ends on December 31, at 11:59 p.m. Mountain Standard Time.

b. The plan Year, if applicable, is indicated in the Group Application.

appendix A
prescription drug list

selecthealth℠

Prescription Drug List—Categorized

This list contains the most commonly prescribed drugs in their most common strengths and formulations. The tiers determine the amount you are responsible to pay. This amount can be found on your ID card or on your Member Payment Summary (MPS) or Schedule of Benefits. This list does not include injectable drug benefits. Please refer to your member materials or contact Member Services at the number below for injectable drug information.

This is not a complete list of all drugs and may change due to new drugs, therapies, or other factors. If you have any questions about your prescription drug benefits, please call Member Services at 801-442-5038 (Salt Lake area) or 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m. For the most current information regarding drug coverage, use the drug look-up tool available at www.selecthealth.org.

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LEGEND

Tier 1 includes generic drugs

Tier 2 includes preferred brand-name drugs

Tier 3 includes non-preferred brand-name drugs

Tier 4 specialty medications

* **Enhanced Formulary—**If your plan includes the "Enhanced" option, Tier 2 drugs in these categories are covered at the Tier 1 benefit. Refer to your Member Payment Summary, Schedule of Benefits, or ID Card for details.

(M) Maintenance Drug—Available for 90-day maintenance drug benefit.

(PA) Preauthorization—Coverage of certain drugs is based on medical necessity. For these drugs, you will need preauthorization from SelectHealth; otherwise, you will be responsible to pay the drug's full retail price.

(QL) Quantity Limits—Quantity limitations apply to certain drugs (maximum number of tablets/ capsules, etc. per prescription). Preauthorization is required if the medication exceeds the plan limits.

(GS) GenericSample℠—The Rx copay will be eliminated for the first fill of certain strengths at the pharmacy.

(ST) Step Therapy—Drugs that require step therapy are covered by SelectHealth only after you have tried the alternative therapy, and it didn't work (the therapy failed).

[GENERIC NAME]—Drug names in brackets, such as [QUINAPRIL], indicate a generic equivalent to the brand-name drug listed is available. Not all generic drugs will be listed.

(Brand name)—Drug names italicized in parentheses, such as (*Nizoral*), indicate a brand-name equivalent to the generic drug listed.

RXSELECT PRESCRIPTION DRUG LIST

ALLERGY

ANTIHISTAMINES

ALLEGRA [FEXOFENADINE] ..... Tier 3
ALLEGRA-D ..... Tier 3
CLARINEX ..... Tier 3
CLARINEX-D ..... Tier 3
FEXOFENADINE (*Allegra*) ..... Tier 1
XYZAL (QL) ..... Tier 3

NASAL PREPARATIONS

ASTELIN (M) ..... Tier 2
ASTEPRO (M) ..... Tier 2
ATROVENT [IPRATROPIUM] (M) ..... Tier 3
BECONASE AQ (M) ..... Tier 3
FLONASE [FLUTICASONE] (M) ..... Tier 3
FLUNISOLIDE (*Nasarel*) (M) ..... Tier 1
FLUTICASONE (*Flonase*) (M) (GS) ..... Tier 1
IPRATROPIUM (*Atrovent*) (M) ..... Tier 1
NASACORT AQ (M) ..... Tier 3
NASAREL [FLUNISOLIDE] (M) ..... Tier 3
NASONEX (M) ..... Tier 2
OMNARIS ..... Tier 3
RHINOCORT AQUA (M) ..... Tier 3
VERAMYST (M) ..... Tier 3

ANTIBIOTICS

CEPHALOSPORINS

CEDAX ..... Tier 3
CEFACLOR (*Ceclor*) ..... Tier 1
CEFADROXIL (*Duricef*) ..... Tier 1
CEFDINIR (*Omnicef*) ..... Tier 1
CEFPROZIL (*Cefzil*) ..... Tier 1
CEFUROXIME (*Ceftin*) ..... Tier 1
CEFZIL [CEFPROZIL] ..... Tier 3
CEPHALEXIN (*Keflex*) ..... Tier 1
KEFLEX [CEPHALEXIN] ..... Tier 3
OMNICEF [CEFDINIR] ..... Tier 3
SUPRAX ..... Tier 3

MACROLIDES

AZITHROMYCIN (*Zithromax*) (QL) ..... Tier 1
BIAXIN [CLARITHROMYCIN] ..... Tier 3
BIAXIN XL [CLARITHROMYCIN ER] ..... Tier 3
CLARITHROMYCIN (*Biaxin*) ..... Tier 1
CLARITHROMYCIN ER (*Biaxin XL*) ..... Tier 1
E.E.S. ..... Tier 1
ERY-TAB ..... Tier 2
ERYTHROMYCIN (*Ery-Tab*) ..... Tier 1
ZITHROMAX [AZITHROMYCIN] (QL) ..... Tier 3
ZMAX (QL) ..... Tier 3

MISC. ANTIBIOTICS

ALINIA (QL) ..... Tier 3
BACTRIM [SMZ-TMP] ..... Tier 3
CLINDAMYCIN (*Cleocin*) ..... Tier 1
KETEK ..... Tier 3
MACROBID [NITROFURANTOIN] ..... Tier 3
METRONIDAZOLE (*Flagyl*) ..... Tier 1
NITROFURANTOIN (*Macrobid*) ..... Tier 1
SMZ-TMP (*Bactrim/Septra*) ..... Tier 1
XIFAXAN (QL) ..... Tier 3
ZYVOX ..... Tier 3

PENICILLINS

AMOX TR-K CLAV (*Augmentin*) ..... Tier 1
AMOXICILLIN (GS) ..... Tier 1
AMOXIL ..... Tier 1
AMPICILLIN ..... Tier 1
AUGMENTIN (*Amox Tr-K Clav*) ..... Tier 3
AUGMENTIN XR ..... Tier 2
MOXATAG (QL) ..... Tier 3
PENICILLIN ..... Tier 1
TRIMOX ..... Tier 1

QUINOLONES

AVELOX ..... Tier 3
CIPRO [CIPROFLOXACIN] ..... Tier 3
CIPRO XR [CIPROFLOXACIN ER] ..... Tier 3
CIPROFLOXACIN (*Cipro*) ..... Tier 1
CIPROFLOXACIN ER (*Cipro XR*) ..... Tier 1
LEVAQUIN ..... Tier 3

TETRACYCLINES

DORYX (ST) ..... Tier 3
DOXYCYCLINE (*Vibramycin*) (GS) ..... Tier 1
MINOCYCLINE (*Dynacin/Minocin*) ..... Tier 1
PERIOSTAT [DOXYCYCLINE] (ST) ..... Tier 3
SOLODYN (ST) ..... Tier 3
TETRACYCLINE (*Sumycin*) ..... Tier 1

ANTIFUNGALS

CLOTRIMAZOLE (*Mycelex*) ..... Tier 1
DIFLUCAN 150mg [FLUCONAZOLE 150mg](QL) ..... Tier 3
DIFLUCAN [FLUCONAZOLE] ..... Tier 3
FLUCONAZOLE 150mg (*Diflucan 150mg*) (QL) ..... Tier 1
FLUCONAZOLE (*Diflucan*) ..... Tier 1
ITRACONAZOLE (*Sporanox*) (QL) (PA) ..... Tier 1
KETOCONAZOLE (*Nizoral*) ..... Tier 1
LAMISIL [TERBINAFINE] (QL) ..... Tier 3
MYCELEX [CLOTRIMAZOLE] ..... Tier 3
NIZORAL [KETOCONAZOLE] ..... Tier 3
NYSTATIN ..... Tier 1
SPORANOX [ITRACONAZOLE] (QL)(PA) ..... Tier 3
TERBINAFINE (*Lamisil*) (QL) ..... Tier 1
VFEND (QL) ..... Tier 3

ANTIVIRALS

ACYCLOVIR (*Zovirax*) ..... Tier 1
FAMCICLOVIR (*Famvir*) ..... Tier 1
FAMVIR [FAMCICLOVIR] ..... Tier 3
VALTREX ..... Tier 3
ZOVIRAX [ACYCLOVIR] ..... Tier 3

ANXIETY & SLEEP DISORDER

ALPRAZOLAM (*Xanax*) ..... Tier 1
ALPRAZOLAM ER (*Xanax XR*) (QL) ..... Tier 1
AMBIEN [ZOLIPIDEM] (QL) (ST) ..... Tier 3
AMBIEN CR (QL) (ST) ..... Tier 3
ATIVAN [LORAZEPAM] ..... Tier 3
BUSPAR [BUSPIRONE] ..... Tier 3
BUSPIRONE (*Buspar*) ..... Tier 1
DIAZEPAM (*Valium*) ..... Tier 1
EDLUAR (QL) (ST) ..... Tier 3
FLURAZEPAM (*Dalmane*) ..... Tier 1
HYDROXYZINE (*Vistaril*) ..... Tier 1
LORAZEPAM (*Ativan*) ..... Tier 1
LUNESTA (QL) (ST) ..... Tier 3
ROZEREM (QL) ..... Tier 2
SONATA [ZALEPON] (QL) (ST) ..... Tier 3
TEMAZEPAM (*Restoril*) ..... Tier 1
XANAX [ALPRAZOLAM] ..... Tier 3
XANAX XR [ALPRAZOLAM ER] (QL) ..... Tier 3
ZOLIPIDEM (*Ambien*) (QL) ..... Tier 1
ZALEPON (*Sonata*) (QL) ..... Tier 1

ASTHMA*

ACCOLATE (M) (QL) ..... Tier 2
ADVAIR (M) ..... Tier 2
ALBUTEROL [VENTOLIN] (M) ..... Tier 1
ASMANEX (M) (QL) ..... Tier 2
ATROVENT HFA (M) ..... Tier 3
AZMACORT (M) ..... Tier 3
BROVANA (QL) (M) ..... Tier 3
COMBIVENT (M) ..... Tier 3
CROMOLYN (*Intal*) (M) ..... Tier 1
FLOVENT HFA (M) ..... Tier 2
FORADIL (M) ..... Tier 3
MAXAIR (M) ..... Tier 2
PROAIR HFA (M) ..... Tier 2
PROVENTIL HFA (M) ..... Tier 3
PULMICORT (M) ..... Tier 2
QVAR (M) ..... Tier 2
SEREVENT (M) ..... Tier 2
SINGULAIR 10 mg (ST) (QL) (M) ..... Tier 2
SINGULAIR 4 mg and 5 mg (QL) (M) ..... Tier 2
SPIRIVA (QL) (M) ..... Tier 2
SYMBICORT (M) ..... Tier 2
THEOPHYLLINE (M) ..... Tier 1
UNIPHYL (M) ..... Tier 2
VENTOLIN HFA (M) ..... Tier 2
XOPENEX (M) ..... Tier 3
XOPENEX HFA (M) ..... Tier 3
ZYFLO CR (ST) (M) (QL) ..... Tier 3

CARDIOVASCULAR

ACE INHIBITORS*

ACCUPRIL [QUINAPRIL] (M) ..... Tier 3
ACEON (M) ..... Tier 3
ALTACE [RAMIPRIL] (M) ..... Tier 3
BENAZEPRIL (*Lotensin*) (M) (GS) ..... Tier 1
CAPOTEN [CAPTOPRIL] (M) ..... Tier 3
CAPTOPRIL (*Capoten*) (M) ..... Tier 1
ENALAPRIL (*Vasotec*) (M) (GS) ..... Tier 1
FOSINOPRIL (*Monopril*) (M) ..... Tier 1
LISINOPRIL (*Prinivil/Zestril*) (M) ..... Tier 1
MAVIK [TRANDOLAPRIL] (M) ..... Tier 3
PRINIVIL [LISINOPRIL] (M) ..... Tier 3
QUINAPRIL (*Accupril*) (M) (GS) ..... Tier 1
RAMIPRIL (*Altace*) (M) ..... Tier 1
TRANDOLAPRIL (*Mavik*) (M) ..... Tier 1

ALPHA- 1 BLOCKERS*

DOXAZOSIN (*Cardura*) (M) ..... Tier 1
HYTRIN [TERAZOSIN] (M) ..... Tier 3

PRAZOSIN (*Minipress*) (M) ..... Tier 1
TERAZOSIN (*Hytrin*) (M) ..... Tier 1

ANGIOTENSIN II RECEPTOR BLOCKERS*

ATACAND (ST) (M) (QL)..... Tier 3
AVAPRO (ST) (M) (QL) ..... Tier 3
BENICAR (ST) (M) (QL)..... Tier 3
COZAAR (M) (QL)..... Tier 2
DIOVAN (M) (QL) ..... Tier 2
MICARDIS (ST) (M) (QL) ..... Tier 3
TEVETEN (ST) (M) (QL)..... Tier 3

ANTIADRENERGICS*

ALDOMET [METHYLDOPA] ..... Tier 3
CATAPRES [CLONIDINE] (M)..... Tier 3
CATAPRES TTS (M)..... Tier 3
CLONIDINE (*Catapres*) (M)..... Tier 1
METHYLDOPA (*Aldomet*) (M) ..... Tier 1

BETA-BLOCKERS*

ATENOLOL (*Tenormin*) (M) ..... Tier 1
BETAPACE AF [SOTALOL/AF] (M) ..... Tier 3
BISOPROLOL (*Zebeta*) (M)..... Tier 1
BYSTOLIC (QL)..... Tier 3
CARVEDILOL *(Coreg)* ..... Tier 1
COREG (*Carvedilol*) (M)..... Tier 3
COREG CR (M) ..... Tier 2
IMDUR [ISOSORBIDE MONONITRATE] (M) ..... Tier 3
INDERAL LA [PROPRANOLOL ER] (M) ..... Tier 3
INNOPRAN XL (M)..... Tier 2
ISORDIL [ISOSORBIDE DINITRATE] (M)..... Tier 3
ISOSORBIDE DINITRATE (*Isordil*) (M)..... Tier 1
ISOSORBIDE MONONITRATE
(*Imdur*)(M)..... Tier 1
LABETALOL (*Trandate*) (M) ..... Tier 1
METOPROLOL SUCCINATE
(*Toprol XL*) (M) ..... Tier 1
NITRO-DUR [NITROGLYCERIN] (M) ..... Tier 2
PROPRANOLOL (*Inderal*) (M) ..... Tier 1
PROPRANOLOL ER (*Inderal LA*) (M)..... Tier 1
SOTALOL/AF (*Betapace/AF*) (M) ..... Tier 1
TOPROL XL
[METOPROLOL SUCCINATE] (M)..... Tier 3

BLOOD MODIFIERS

AGGRENOX (M) ..... Tier 2
COUMADIN [WARFARIN] (M)..... Tier 2
EFFIENT (QL) (M) ..... Tier 3
PLAVIX (M)..... Tier 2
WARFARIN (*Coumadin*) (M) ..... Tier 1

CALCIUM CHANNEL BLOCKERS*

AMLODIPINE (*Norvasc*) (M) (GS) ..... Tier 1
CALAN [VERAPAMIL] (M)..... Tier 3
CARDIZEM CD/LA [DILTIAZEM] (M)..... Tier 3
DILTIAZEM (*Tiazac*) (M)..... Tier 1
DILTIAZEM ER (*Cardizem CD*) (M)..... Tier 1
NICARDIPINE (*Cardene*) (M) ..... Tier 1
NIFEDIPINE (*Adalat and Procardia*) (M) ..... Tier 1
NIFEDIPINE ER (*Procardia XL*) (M)..... Tier 1
NORVASC [AMLODIPINE] (M)..... Tier 3
VERAPAMIL (*Calan/Verelan/Isoptin*) (M)..... Tier 1
VERELAN [VERAPAMIL] (M)..... Tier 3

CARDIAC GLYCOSIDES

DIGOXIN (*Lanoxin*) (M) ..... Tier 1
LANOXIN [DIGOXIN] (M) ..... Tier 2

COMBINATIONS/OTHER

AMLODIPINE/BENAZEPRIL
(*Lotrel*) (M)..... Tier 1
ATACAND HCT (ST) (M) (QL)..... Tier 3
AVALIDE (ST) (M) (QL)..... Tier 3
BENAZEPRIL HCTZ
(*Lotensin HCT*) (M) (QL)..... Tier 1
BENICAR HCT (ST) (M) (QL) ..... Tier 3
BISOPROLOL HCTZ (*Ziac*) (M)..... Tier 1
CAPOZIDE [CAPTOPRIL/HCTZ] (M) ..... Tier 3
CAPTOPRIL HCTZ (*Capozide*) (M)..... Tier 1
DIOVAN HCT (M) (QL)..... Tier 2
ENALAPRIL HCTZ (*Vaseretic*) (M) ..... Tier 1
EXFORGE (M) (QL)..... Tier 2
EXFORGE HCT (M) (QL) ..... Tier 2
FOSINOPRIL HCTZ (*Monopril HCT*) (M) ..... Tier 1
HYZAAR (M) (QL)..... Tier 2
LISINOPRIL HCTZ (*Prinzide*) (M) (GS) ..... Tier 1
LOTENSIN HCT
[BENAZEPRIL-HCTZ] (M) (QL) ..... Tier 3
LOTREL [AMLODIPINE/BENAZEPRIL] (M) ..... Tier 3
MICARDIS HCT (ST) (M) (QL)..... Tier 3
QUINARETIC (*Accuretic*) (M)..... Tier 1
RANEXA (ST) (M) (QL) ..... Tier 2
TARKA (M)..... Tier 2
TEKTURNA (ST) (M) (QL) ..... Tier 3
TEVETEN HCT (ST) (M) (QL)..... Tier 3
TYVASO PR (M) ..... Tier 3
VALTURNA (ST) (M) .....Tier 3

DIURETICS (WATER PILLS)*

EPLERENONE [INSPRA] (ST) (M)..... Tier 1
FUROSEMIDE (*Lasix*) (M)..... Tier 1
HYDROCHLOROTHIAZIDE
(*HCTZ*) (M) (GS)..... Tier 1
INSPRA [EPLERENONE] (ST) (M) ..... Tier 3
MAXZIDE [TRIAMTERENE-HCTZ] (M)..... Tier 3
SPIRONOLACTONE (*Aldactone*) (M)..... Tier 1
TRIAMTERENE-HCTZ (*Maxzide*) (M)..... Tier 1

CHOLESTEROL*

ADVICOR (QL) (M) (ST) ..... Tier 3
CADUET (ST) (M)..... Tier 3
CHOLESTYRAMINE (*Questran*) (M)..... Tier 1
CRESTOR 10/20/40mg (QL) (M)..... Tier 2
CRESTOR 5mg (QL) (ST) (M) ..... Tier 2
FENOFIBRATE (*Lofibra*) (QL) (M)..... Tier 1
GEMFIBROZIL (*Lopid*) (QL) (M) ..... Tier 1
LESCOL (QL) (M) ..... Tier 3
LIPITOR (QL) (ST) (M)..... Tier 3
LOVASTATIN (*Mevacor*) (QL) (M) (GS)..... Tier 1
NIASPAN (QL) (M) ..... Tier 2
PRAVACHOL [PRAVASTATIN] (QL) (M)..... Tier 3
PRAVASTATIN (*Pravachol*) (QL) (M) (GS)..... Tier 1
QUESTRAN [CHOLESTYRAMINE] (M) ..... Tier 3
SIMCOR (ST) (QL) ..... Tier 3
SIMVASTATIN (*Zocor*) (QL) (M) (GS) ..... Tier 1
TRICOR (QL) (M)..... Tier 3
VYTORIN 10/10 mg (QL) (ST) (M) ..... Tier 2
VYTORIN
10/20, 10/40, 10/80 mg (QL) (M) ..... Tier 2
WELCHOL (M)..... Tier 2
ZETIA (QL) (M) ..... Tier 2
ZOCOR [SIMVASTATIN] (QL) (M) ..... Tier 3

CONTRACEPTION (BIRTH CONTROL)*

APRI (*Desgen and Ortho-Cept*) (M)..... Tier 1
CESIA (*Cyclessa*) (M) ..... Tier 1
CYCLESSA [CESIA & VELIVET] (M) ..... Tier 3
DEMULEN (M)..... Tier 3
DESOGEN ..... Tier 3
KARIVA *(Mircette)* (M) ..... Tier 1
LEVORA *(Nordette)* (M)..... Tier 1
LOESTRIN FE (*Microgestin*) (M)..... Tier 3
LYBREL (M) ..... Tier 3
MICROGESTIN/FE (*Loestrin*) (M)..... Tier 1
MIRCETTE [KARIVA] (M)..... Tier 3
NECON (*Ortho-Novum*) (M) ..... Tier 1
NORTREL (*Ortho-Novum*) (M)..... Tier 1
NUVARING (QL) (M)..... Tier 2
OCELLA (*Yasmin 28*) (M)..... Tier 1
ORTHO EVRA (QL) (M)..... Tier 3
ORTHO MICRONOR (M)..... Tier 3
ORTHO TRI-CYCLEN LO (M) ..... Tier 3
ORTHO-CEPT (M)..... Tier 3
ORTHO-CYCLEN (M)..... Tier 3
ORTHO-NOVUM (M)..... Tier 3
OVCON (M)..... Tier 3
PREVIFEM (*Ortho-Cyclen*) (M) ..... Tier 1
QUASENSE (*Seasonale*) (QL) (M)..... Tier 1
SEASONALE (QL) (M) ..... Tier 3
SEASONIQUE [QUASENSE] (QL) (M) ..... Tier 3
SOLIA (*Desogen and Ortho-Cept*) (M)..... Tier 1
SPRINTEC (*Ortho-Cyclen*) (M)..... Tier 1
TRINESSA *(Ortho Tri-Cyclen)* (M) ..... Tier 1
TRIPHASIL 28 (M) ..... Tier 1
TRI-PREVIFEM (*Ortho Tri-Cyclen*) (M) ..... Tier 1
VELIVET (*Cyclessa*) (M) ..... Tier 1
YASMIN 28 [OCELLA] (M)..... Tier 3
YAZ (M) ..... Tier 2
ZOVIA 1/50E (*Demulen*) (M) ..... Tier 1

DERMATOLOGICALS (SKIN)

ACNE

ACCUTANE [ISOTRETINOIN]..... Tier 3
ACZONE ..... Tier 3
AMNESTEEM (*Accutane*) ..... Tier 1
AZELEX ..... Tier 3
BENZACLIN ..... Tier 2
BENZAMYCIN [ERYTH/BP]..... Tier 3
BENZOYL PEROXIDE (*Benzac*)..... Tier 1
BREVOXYL (QL)..... Tier 3
CLARAVIS (*Accutane*)..... Tier 1
DIFFERIN (age limit) ..... Tier 2
DUAC /CS..... Tier 2
EPIDUO (*age limit*) ..... Tier 3
ERYTH-BP (*Benzamycin*)..... Tier 1
ERYTHROMYCIN..... Tier 1
ISOTRETINOIN (*Accutane*)..... Tier 1
METROCREAM [METRONIDAZOLE] ..... Tier 3

METROGEL ..... Tier 3
METROLOTION [METRONIDAZOLE] ..... Tier 2
METRONIDAZOLE (*Metrolotion*) ..... Tier 1
RETIN-A (age limit) [TRETINOIN] ..... Tier 3
RETIN-A MICRO (age limit) ..... Tier 2
SOTRET (*Accutane*) ..... Tier 1
TRETINOIN (age limit) (*Retin-A*) ..... Tier 1
ZIANA (age limit) ..... Tier 3

ANTIFUNGALS

CICLOPIROX (*Loprox/Penlac*) ..... Tier 1
CLOTRIMAZOLE ..... Tier 1
CLOTRIMAZOLE-BETAMETH (*Lotrisone*) ..... Tier 1
KETOCONAZOLE (*Nizoral*) ..... Tier 1
PENLAC (*Ciclopirox*) (QL) ..... Tier 3

ANTIPSORIATICS

DOVONEX ..... Tier 2
SORIATANE ..... Tier 2
TAZORAC ..... Tier 2
VECTICAL ..... Tier 3

MISC. DERMATOLOGICALS

ALDARA ..... Tier 2
ALTABAX ..... Tier 3
BACTROBAN [MUPIROCIN] ..... Tier 2
CARAC ..... Tier 2
EFUDEX [FLUOROURACIL] ..... Tier 3
ELIDEL (ST) ..... Tier 2
FLUOROURACIL (*Efudex*) ..... Tier 1
MUPIROCIN (*Bactroban*) ..... Tier 1
ORACEA (ST) ..... Tier 3
PROTOPIC (ST) ..... Tier 2
REGRANEX (QL) ..... Tier 3

STEROIDS

BETAMETHASONE (*Diprolene*) ..... Tier 1
CLOBETASOL (*Temovate*) ..... Tier 1
DERMATOP [PREDNICARBATE] ..... Tier 3
DESONIDE (*Desowen*) ..... Tier 1
ELOCON [MOMETASONE] ..... Tier 3
HYDROCORTISONE (*Hytone*) ..... Tier 1
KENALOG [TRIAMCINOLONE] ..... Tier 3
LIDEX [FLUOCINONIDE] ..... Tier 3
MOMETASONE (*Elocon*) ..... Tier 1
OLUX ..... Tier 3
PREDNICARBATE (*Dermatop*) ..... Tier 1
TEMOVATE [CLOBETASOL] ..... Tier 3
TRIAMCINOLONE ACETONIDE (*Kenalog*) ..... Tier 1
WESTCORT [HYDROCORTISONE] ..... Tier 3

DIABETIC*

INJECTABLE AND OTHER

APIDRA (M) ..... Tier 3
BYETTA (QL) (ST) (M) ..... Tier 2
FREESTYLE TEST STRIPS (QL) (M) ..... Tier 2
GLUCAGON ..... Tier 2
HUMALOG (PA) (M) ..... Tier 3
HUMALOG 50/50 and 75/25 (M) ..... Tier 2
HUMULIN (PA) (M) ..... Tier 3
LANTUS (M) ..... Tier 2
LEVEMIR (M) ..... Tier 2
NOVOLIN ..... Tier 2
NOVOLOG (M) ..... Tier 2
PRECISION TEST STRIPS (QL) (M) ..... Tier 2
SYMLIN (QL) (ST) (M) ..... Tier 2
SYMLIN PEN (QL) (ST) (M) ..... Tier 2

ORAL ANTIDIABETICS

ACARBOSE (*Precose*) (M) ..... Tier 1
ACTOPLUS MET (M) ..... Tier 2
ACTOS (QL) (M) ..... Tier 2
AMARYL [GLIMEPIRIDE] (M) ..... Tier 3
AVANDAMET (M) ..... Tier 2
AVANDARYL (M) ..... Tier 2
AVANDIA (M) (QL) ..... Tier 2
DUETACT (M) ..... Tier 2
GLIMEPIRIDE (*Amaryl*) (M) ..... Tier 1
GLIPIZIDE (*Glucotrol*) (M) ..... Tier 1
GLIPIZIDE XL (*Glucotrol XL*) (M) ..... Tier 1
GLIPIZIDE-MET (*Metaglip*) ..... Tier 1
GLUCOPHAGE [METFORMIN] (M) ..... Tier 3
GLUCOPHAGE XR [METFORMIN] (M) ..... Tier 3
GLUCOTROL [GLIPIZIDE] (M) ..... Tier 3
GLUCOTROL XL [GLIPIZIDE ER] (M) ..... Tier 3
GLUCOVANCE [GLYBURIDE/MET] (M) ..... Tier 3
GLYBURIDE (*Diabeta/Micronase*) (M) ..... Tier 1
GLYBURIDE/MET (*Glucovance*) (M) ..... Tier 1
JANUMET (QL) (M) ..... Tier 2
JANUVIA (QL) (M) ..... Tier 2
METAGLIP [GLIPIZIDE-METFORMIN] (M) ..... Tier 3
METFORMIN (*Glucophage*) (M) (GS) ..... Tier 1
METFORMIN ER (*Glucophage XR*) (M) (GS) ..... Tier 1
ONGLYZA (QL) (M) ..... Tier 3
PRANDIN (M) ..... Tier 2
PRECOSE [ACARBOSE] (M) ..... Tier 3

GASTROINTESTINAL (DIGESTIVE)

MISC. GASTROINTESTINAL

AMITIZA (QL) ..... Tier 2
ASACOL (M) ..... Tier 2
DIPHENOXYLATE-ATROPINE (*Lomotil*) ..... Tier 1
ENTOCORT EC ..... Tier 3
LIALDA (QL) (M) ..... Tier 2
LOTRONEX (QL) (PA) (M) ..... Tier 3
METOCLOPRAMIDE HCL (*Reglan*) (M) ..... Tier 1
RENVELA (M) ..... Tier 2
PENTASA (M) ..... Tier 2

NAUSEA & VOMITING

ANZEMET (QL) ..... Tier 3
EMEND (QL) ..... Tier 3
GRANISETRON (QL) (*Kytril*) ..... Tier 1
KYTRIL [GRANISETRON] (QL) ..... Tier 3
ONDANSETRON (*Zofran*) (QL) ..... Tier 1
ONDANSETRON ODT (*Zofran ODT*) (QL) ..... Tier 1
PHENERGAN [PROMETHAZINE] ..... Tier 3
PROMETHAZINE (*Phenergan*) ..... Tier 1
ZOFRAN [ONDANSETRON] (QL) ..... Tier 3
ZOFRAN ODT [ONDANSETRON ODT] (QL) ..... Tier 3

ULCER TREATMENTS

ACIPHEX (QL) (ST) (M) ..... Tier 2
CIMETIDINE (*Tagamet*) (M) ..... Tier 1
FAMOTIDINE (*Pepcid*) (QL) (M) ..... Free
HYOSCYAMINE (*Levsin*) (M) ..... Tier 1
KAPIDEX (ST) (QL) ..... Tier 3
NEXIUM (QL) (ST)(M) ..... Tier 3
OMEPRAZOLE (*Prilosec*) (QL) (M) (GS) ..... Tier 1
PANTOPRAZOLE (*Protonix*) (QL) (ST) (M) ..... Tier 1
PREVACID (QL) (ST) (M) ..... Tier 2
PREVPAC (QL) (M) ..... Tier 2
PRILOSEC [OMEPRAZOLE] (QL) (ST) (M) ..... Tier 3
PROTONIX [PANTOPRAZOLE] (QL) (ST) (M) ..... Tier 3
PYLERA (M) ..... Tier 3
RANITIDINE HCL (*Zantac*) (QL) (M) ..... Free
ZANTAC [RANITIDINE] (QL) (M) ..... Tier 3
ZEGERID (QL) (ST) (M) ..... Tier 3

HORMONE REPLACEMENT THERAPY

FEMALE

ACTIVELLA (M) ..... Tier 2
CENESTIN (M) ..... Tier 2
CLIMARA [ESTRADIOL] (M) ..... Tier 2
CRINONE (minimum age) ..... Tier 3
ENJUVIA (M) ..... Tier 2
ESTRADERM (M) ..... Tier 2
ESTRADIOL (*Estrace*) (M) ..... Tier 1
ESTRADIOL PATCH (*Climara*) (M) ..... Tier 1
ESTRATEST [SYNTEST] (M) ..... Tier 2
ESTRING ..... Tier 2
ESTROGEL (M) ..... Tier 2
ESTROPIPATE (*Ogen*) (M) ..... Tier 1
FEMHRT (M) ..... Tier 3
FEMTRACE (M) ..... Tier 3
MEDROXYPROGESTERONE (*Provera*) (M) ..... Tier 1
NORETHINDRONE (*Aygestin*) (M) ..... Tier 1
PREMARIN (M) ..... Tier 2
PREMPHASE (M) ..... Tier 2
PREMPRO (M) ..... Tier 2
PROGESTERONE (PA) ..... Tier 3
PROMETRIUM (minimum age) (M) ..... Tier 2
PROVERA [MEDROXYPROGESTERONE] (M) ..... Tier 3
SYNTEST (*Estratest*) ..... Tier 1
VAGIFEM (M) ..... Tier 2
VIVELLE (M) ..... Tier 2
VIVELLE-DOT (M) ..... Tier 2

MALE

ANDRODERM (ST) (M) ..... Tier 2
ANDROGEL (M) ..... Tier 2
TESTIM (ST) (M) ..... Tier 3
STRIANT (ST) (M) ..... Tier 3

IMMUNOSUPPRESSANTS

AZATHIOPRINE (*Imuran*) (M) ..... Tier 1
CELLCEPT [MYCOPHENOLATE] (M) ..... Tier 2
CYCLOSPORINE (*Sandimmune and Neoral*) (M) ..... Tier 1
GENGRAF (*Neoral*) (M) ..... Tier 1
IMURAN [AZATHIOPRINE] (M) ..... Tier 3

MYCOPHENOLATE *(Cellcept)* (M) ..... Tier 1
MYFORTIC (M) ..... Tier 3
NEORAL *(Cyclosporin)* (M) ..... Tier 2
PROGRAF (M) ..... Tier 2
RAPAMUNE (M) ..... Tier 2
SANDIMMUNE [CYCLOSPORINE] (M) ..... Tier 2

MENTAL HEALTH

ADHD/STIMULANTS (ATTENTION DEFICIT & HYPERACTIVITY)

ADDERALL [AMPHETAMINE SALTS] ..... Tier 3
ADDERALL XR (QL) ..... Tier 3
AMPHETAMINE SALT *(Adderall)* ..... Tier 1
AMPHETAMINE SALT ER (QL) ..... Tier 3
CONCERTA (QL) ..... Tier 2
DAYTRANA (QL) ..... Tier 3
DEXEDRINE [DEXTROAM] (QL) ..... Tier 3
DEXEDRINE CR [DEXTROAM SR] (QL) ..... Tier 3
DEXTROAM *(Dexedrine)* (QL) ..... Tier 1
DEXTROAM SR *(Dexedrine CR)* (QL) ..... Tier 1
FOCALIN XR (QL) ..... Tier 3
METADATE CD ..... Tier 3
METADATE ER [METHYLIN ER] ..... Tier 3
METHYLIN ..... Tier 3
METHYLPHENIDATE *(Ritalin)* ..... Tier 1
MYCOPHENOLATE *(Cellcept)* (M) ..... Tier 1
NUVIGIL (QL) (PA) ..... Tier 3
PROVIGIL (QL) (PA) ..... Tier 3
RITALIN [METHYLPHENIDATE] ..... Tier 3
RITALIN LA (QL) ..... Tier 3
RITALIN SR [METHYLPHENIDATE] (QL) ..... Tier 3
STRATTERA (QL) ..... Tier 3
VYVANSE (QL) ..... Tier 2
XYREM (PA) ..... Tier 3

ALZHEIMERS

ARICEPT (M) ..... Tier 2
EXELON (M) ..... Tier 3
GALANTAMINE *(Razadyne)* (M) ..... Tier 1
GALANTAMINE ER *(Razadyne ER)* (M) ..... Tier 1
NAMENDA (M) ..... Tier 2
RAZADYNE [GALANTAMINE] (M) ..... Tier 3
RAZADYNE ER [GALANTAMINE ER] (M) ..... Tier 3

ANTIDEPRESSANTS

AMITRIPTYLINE *(Elavil)* (M) ..... Tier 1
APLENZIN (QL) (ST) ..... Tier 3
BUPROPION,SR,XL *(Wellbutrin,SR,XL)*(QL)(M)(GS) ..... Tier 1
CELEXA [CITALOPRAM] (QL) (ST) (M) ..... Tier 3
CITALOPRAM *(Celexa)* (QL) (M) (GS) ..... Tier 1
CYMBALTA (ST) (M) (QL) ..... Tier 2
DESYREL [TRAZODONE] (M) ..... Tier 3
EFFEXOR [VENLAFAXINE] (ST) (M) ..... Tier 3
EFFEXOR XR (QL) (ST) (M) ..... Tier 2
EMSAM (QL) (ST) (M) ..... Tier 3
FLUOXETINE *(Prozac)* (M) (GS) ..... Tier 1
IMIPRAMINE *(Tofranil)* (M) ..... Tier 1
LEXAPRO (QL) (ST) ..... Tier 3
MIRTAZAPINE *(Remeron)* (QL) (M) ..... Tier 1
NORTRIPTYLINE *(Pamelor)* (M) ..... Tier 1
PAMELOR [NORTRIPTYLINE] (M) ..... Tier 3
PAROXETINE *(Paxil)* (QL) (M) (GS) ..... Tier 1
PAXIL [PAROXETINE] (QL) (ST) (M) ..... Tier 3
PAXIL CR (QL) (ST) (M) ..... Tier 3
PEXEVA (QL) (ST) (M) ..... Tier 3
PRISTIQ (QL) (ST) (M) ..... Tier 2
PROZAC [FLUOXETINE] (QL) (ST) (M) ..... Tier 3
RAPIFLUX [FLUOXETINE] (ST) ..... Tier 3
REMERON [MIRTAZAPINE] (ST) (M) (QL) ..... Tier 3
SARAFEM (ST) (M) ..... Tier 3
SERTRALINE *(Zoloft)* (QL) (M) (GS) ..... Tier 1
TRAZODONE *(Desyrel)* (M) ..... Tier 1
VENLAFAXINE *(Effexor)* (M) ..... Tier 1
VENLAFAXINE ER (QL) ..... Tier 3
WELLBUTRIN [BUPROPION] (QL) (ST) (M) ..... Tier 3
WELLBUTRIN SR [BUPROPION SR](QL)(ST)(M) ..... Tier 3
WELLBUTRIN XL [BUPROPRION XL](QL)(ST)(M) ..... Tier 3
ZOLOFT [SERTRALINE] (QL) (ST) (M) ..... Tier 3

ANTIPSYCHOTICS

ABILIFY (QL) (M) ..... Tier 2
CLOZAPINE *(Clozaril)* (M) ..... Tier 1
GEODON (QL) (M) ..... Tier 2
HALOPERIDOL (M) ..... Tier 1
INVEGA (QL) (PA) (M) ..... Tier 3
RISPERDAL [RISPERIDONE] (QL) (M) ..... Tier 3
RISPERDONE *(Risperdal)* (QL) (M) ..... Tier 1
SAPHRIS (ST) (M) ..... Tier 3
SEROQUEL, XR (QL) (M) ..... Tier 2
SYMBYAX (M) ..... Tier 3
ZYPREXA (QL) (M) ..... Tier 2

MIGRAINE

AMERGE (QL) ..... Tier 2
APAP W/ BUTALBITAL *(Phrenilin)* (QL) ..... Tier 1
AXERT (QL) ..... Tier 3
BUTALBITAL-APAP-CAFFEINE *(Esgic)* ..... Tier 1
BUTALBITAL-ASA-CAFFEINE *(Fiorinal)* ..... Tier 1
CAFERGOT [ERGOTAMINE/CAFF.] ..... Tier 3
FIORICET [BUTALBITAL/APAP/CAFF.] ..... Tier 3
FROVA (QL) ..... Tier 3
IMITREX [SUMATRIPTAN] (QL) ..... Tier 3
MAXALT/ MLT (QL) ..... Tier 2
RELPAX (QL) ..... Tier 3
SUMATRIPTAN *(Imitrex)* (QL) ..... Tier 1
TREXIMET (QL) ..... Tier 3
ZOMIG (QL) ..... Tier 3
ZOMIG ZMT (QL) ..... Tier 3

MUSCLE RELAXANTS

AMRIX® (QL) (PA) ..... Tier 3
BACLOFEN ..... Tier 1
CARISOPRODOL CMP/CODEINE ..... Tier 1
CARISOPRODOL/ CMP *(Soma/ CMP)* (QL) ..... Tier 1
CYCLOBENZAPRINE *(Flexeril)* ..... Tier 1
FLEXERIL *(Cyclobenzaprine)* ..... Tier 3
METHOCARBAMOL *(Robaxin)* ..... Tier 1
ROBAXIN [METHOCARBAMOL] ..... Tier 3
SKELAXIN ..... Tier 3
SOMA /CMP [CARISOPRODO/ CMP] (QL) ..... Tier 3
SOMA 250 mg (PA) ..... Tier 3
TIZANIDINE *(Zanaflex)* ..... Tier 1
ZANAFLEX [TIZANIDINE] ..... Tier 3

ONCOLOGICS/HEMATOLOGY

AFINITOR (QL) (PA) ..... Tier 2
ARIMIDEX (QL) (M) ..... Tier 2
AROMASIN (QL) (M) ..... Tier 2
CHROMAGEN (PA) ..... Tier 3
GLEEVEC ..... Tier 2
HYCAMTIN (QL) ..... Tier 2
IRESSA (PA) ..... Tier 2
NEXAVAR (PA) ..... Tier 2
PROMACTA (PA) ..... Tier 2
REVLIMID (QL) (PA) ..... Tier 2
SPRYCEL (QL) (PA) ..... Tier 2
SUTENT (PA) ..... Tier 2
TAMOXIFEN (M) ..... Tier 1
TARCEVA (PA) ..... Tier 2
TARGRETIN (QL) ..... Tier 2
TASIGNA (PA) ..... Tier 2
TYKERB (QL) (PA) ..... Tier 2
XELODA ..... Tier 2
ZOLINZA (QL) (PA) ..... Tier 2

OPHTHALMICS (EYE)

ANTI-INFECTIVES

CILOXAN [CIPROFLOXACIN] ..... Tier 3
CIPROFLOXACIN *(CIPRO)* ..... Tier 1
GENTAMICIN ..... Tier 1
OCUFLOX [OFLOXACIN] ..... Tier 2
OFLOXACIN *(Ocuflox)* ..... Tier 1
TOBRAMYCIN ..... Tier 1
VIGAMOX ..... Tier 3
ZYMAR ..... Tier 3

MISC. OPHTHALMICS

ALOCRIL (M) ..... Tier 2
ALOCRIL (M) ..... Tier 2
COSOPT [DORZOLAMIDE-TIMOLOL] (M) ..... Tier 3
CROMOLYN *(Crolom)* ..... Tier 1
DORZOLAMIDE *(Trusopt)* (M) ..... Tier 1
DORZOLAMIDE-TIMOLOL *(Cosopt)* (M) ..... Tier 1
ELESTAT ..... Tier 2
OPTIVAR ..... Tier 2
PATADAY (M) ..... Tier 3
PATANOL ..... Tier 2
RESTASIS ..... Tier 3
TIMOLOL *(Timoptic)* (M) ..... Tier 1
TRUSOPT [DORZOLAMIDE] (M) ..... Tier 3

PROSTAGLANDINS

COMBIGAN (M) (QL) ..... Tier 2
LUMIGAN (M) ..... Tier 2
XALATAN (M) ..... Tier 2

OSTEOPOROSIS TREATMENTS*

ACTONEL (QL) (M) (ST) ..... Tier 2
ALENDRONATE *(Fosamax)* (QL) (M) (GS) ..... Tier 1
BONIVA (QL) (M) (PA) ..... Tier 3
EVISTA (QL) (M) ..... Tier 2

FOSAMAX (*Alendronate*) (QL) (M) (ST) ..... Tier 3
FOSAMAX D (*Alendronate*) (QL) (M) (ST)..... Tier 2
MIACALCIN [CALCITONIN] (M) ..... Tier 2

OTIC PREPARATIONS (EAR)

CIPRO HC ..... Tier 2
CIPRODEX ..... Tier 2
FLOXIN [OFLOXACIN] ..... Tier 3
OFLOXACIN (*Floxin*)..... Tier 1

PAIN MEDICATIONS

NARCOTIC ANALGESICS

ACTIQ [FENTANYL] (QL) (PA)..... Tier 3
AVINZA (QL)..... Tier 2
BUTALBITAL
CAFF-APAP-cod(*Fioricet w/ Cod*)(QL) ..... Tier 1
BUTORPHANOL (*Stadol*) (QL)..... Tier 1
DURAGESIC [FENTANYL] (QL)..... Tier 3
EMBEDA PR .....Tier 3
FENTANYL (*Actiq*) (QL) (PA) ..... Tier 1
FENTANYL (*Duragesic*) (QL) ..... Tier 1
FENTORA (QL) (PA) ..... Tier 3
HYDROCODONE
W/APAP (*Lortab/Vicodin*) (QL) ..... Tier 1
KADIAN (QL) ..... Tier 2
LORCET [HYDROCODONE-APAP] (QL) ..... Tier 3
LORTAB [HYDROCODONE/APAP] (QL) ..... Tier 3
MORPHINE SULFATE (*MS Contin*) ..... Tier 1
MS CONTIN [MORPHINE SULFATE] (QL)..... Tier 3
NUCYNTA (QL) (PA) ..... Tier 3
OPANA ER (QL) (PA)..... Tier 3
OXYCODONE-APAP (*Percocet*) (QL) ..... Tier 1
OXYCODONE-ASPIRIN (*Percodan*) (QL) ... Tier 1
OXYCONTIN (QL) (ST) ..... Tier 3
PERCOCET [OXYCODONE/APAP] (QL) ..... Tier 3
PROPOXYPHENE (*Darvon*) (QL) ..... Tier 1
PROPOXYPHENE-APAP
(*Darvocet*) (QL) ..... Tier 1
TRAMADOL (*Ultram*) (QL) ..... Tier 1
TRAMADOL-APAP (*Ultracet*) (QL) ..... Tier 1
ULTRACET [TRAMADOL/APAP] (QL) ..... Tier 3
ULTRAM [TRAMADOL/APAP] (QL) ..... Tier 3
ULTRAM ER (QL) ..... Tier 3
VICODIN [HYDROCODONE-APAP] (QL) ..... Tier 3
VICOPROFEN [HYDROCODONE-IBU] (QL) .. Tier 3

NON-STEROIDAL ANTI-INFLAMMATORIES

ARTHROTEC (M)..... Tier 3
CELEBREX (QL) (M) ..... Tier 3
DAYPRO [OXAPROZIN] (M) ..... Tier 3
DICLOFENAC (*Voltaren*) (M) (GS)..... Tier 1
FELDENE [PIROXICAM] (M) ..... Tier 3
IBUPROFEN (*Motrin*) (M) (GS) ..... Tier 1
INDOMETHACIN (*Indocin*) (M) ..... Tier 1
KETOROLAC (*Toradol*) (QL) ..... Tier 1
MELOXICAM (*Mobic*) (M) ..... Tier 1
MOBIC [MELOXICAM] (M)..... Tier 3
MOTRIN [IBUPROFEN] (M) ..... Tier 3
NABUMETONE (*Relafen*) (M) ..... Tier 1
NAPROXEN (*Naprosyn*) (M) (GS) ..... Tier 1
OXAPROZIN (*Daypro*) (M)..... Tier 1
PIROXICAM (*Feldene*) (M) ..... Tier 1
PREVACID NAPRAPAC (M)..... Tier 2

PRENATAL VITAMINS*

Prenatal Vitamins- Brand (M) ..... Tier 3
Prenatal Vitamins- Generic (M)..... Tier 1

PROSTATE

AVODART (M) ..... Tier 3
CARDURA [DOXAZOSIN] (M) ..... Tier 3
DOXAZOSIN (*Cardura*) (M) (GS)..... Tier 1
FINASTERIDE (*Proscar*) (ST) (M)..... Tier 1
FLOMAX (M)..... Tier 2
PRAZOSIN (*Minipress*) (M)..... Tier 1
PROSCAR [FINASTERIDE] (ST) (M)..... Tier 3
TERAZOSIN (*Hytrin*) (M)..... Tier 1
UROXATRAL (M)..... Tier 3

SEIZURE DISORDER

SABRIL PR (QL) (M)..... Tier 3
BANZEL (M) ..... Tier 3
CARBAMAZEPINE (*Tegretol*) (M)..... Tier 1
CARBATROL (M)..... Tier 2
CLONAZEPAM (*Klonopin*) (M) ..... Tier 1
DEPAKOTE [DIVALPROEX] (M) (QL)..... Tier 3
DILANTIN [PHENYTOIN] (M)..... Tier 2
DIVALPROEX [DEPAKOTE] (M) ..... Tier 1
GABAPENTIN (*Neurontin*) (QL) (M) ..... Tier 1
GABITRIL (QL) (M)..... Tier 2
KEPPRA [LEVETIRACETAM] (QL) (M)..... Tier 3
KEPPRA XR (QL) (M) ..... Tier 3
LAMICTAL/ODT
[LAMOTRIGINE/ODT] (QL) (M)..... Tier 3
LAMICTAL XR (QL) (M)..... Tier 3
LAMOTRIGINE (*Lamictal*) (QL) (M) ..... Tier 1
LEVETIRACETAM (*Keppra*) (QL) (M) ..... Tier 1
LYRICA (QL) (M) ..... Tier 3
NEURONTIN [GABAPENTIN] (QL) (M)..... Tier 3
OXCARBAZEPINE (*Trileptal*) (QL) (M)..... Tier 1
PHENYTOIN (*Dilantin*) (M)..... Tier 1
TEGRETOL [CARBAMAZEPINE] (M)..... Tier 2
TOPAMAX [TOPIRAMATE] (QL) (M) ..... Tier 3
TOPIRAMATE (*Topamax*) (QL) (M) ..... Tier 1
TRILEPTAL [OXCARBAZEPINE] (QL) (M)..... Tier 3
VIMPAT (QL) (M) ..... Tier 2
ZONEGRAN [ZONISAMIDE] (QL) (M)..... Tier 3
ZONISAMIDE (*Zonegran*) (QL) (M) ..... Tier 1

SMOKING CESSATION*

BUPROPION HCL (*Zyban*) (QL) ..... Tier 1
CHANTIX (QL)..... Tier 2
ZYBAN [BUPROPION] (QL) ..... Tier 2

STEROIDS

HYDROCORTISONE (*Cortef*) (M)..... Tier 1
MEDROL [METHYLPREDNISOLONE] ..... Tier 3
METHYLPREDNISOLONE (*Medrol*)..... Tier 1
ORAPRED
[PREDNISOLONE SOD PHOSPHATE] ..... Tier 3
PREDNISOLONE (*Prelone*) ..... Tier 1
PREDNISOLONE SOD PHOS
(*Orapred*)..... Tier 1
PREDNISONE (*Sterapred*) (M) ..... Tier 1
PRELONE [PREDNISOLONE] (M)..... Tier 3

THYROID

ARMOUR THYROID [THYROID] (M)..... Tier 3
CYTOMEL (M) ..... Tier 2
LEVOTHROID (M) ..... Tier 2
LEVOXL (M)..... Tier 2
SYNTHROID (M) ..... Tier 1
UNITHROID (M)..... Tier 2

URINARY INCONTINENCE

DDAVP [DESMOPRESSIN] (PA) ..... Tier 3
DESMOPRESSIN (*DDAVP*) (PA)..... Tier 1
DETROL (M) ..... Tier 3
DETROL LA (M) ..... Tier 3
DITROPAN [OXYBUTIN] (M) ..... Tier 3
DITROPAN XL [OXYBUTININ ER] (M) ..... Tier 3
ENABLEX (M)..... Tier 3
HYOSCYAMINE (*Cystospaz*) (M) ..... Tier 1
MINIRIN (PA)..... Tier 1
OXYBUTYNIN ER (*Ditropan*) (M)..... Tier 1
OXYTROL (M) ..... Tier 3
STIMATE ..... Tier 3
TOVIAZ (M)..... Tier 3
VESICARE (M)..... Tier 3

UNCATEGORIZED

ADCIRCA (PA) ..... Tier 3
KUVAN (PA) ..... Tier 3
LETAIRIS (PA)..... Tier 3
REVATIO (PA)..... Tier 3
TRACLEER (PA) ..... Tier 3
ULORIC (ST)(QL) ..... Tier 3
XENAZINE (PA) (QL)..... Tier 2

appendix B
benefit riders

selecthealth℠

MENTAL HEALTH/CHEMICAL DEPENDENCY BENEFIT RIDER

1. Your Mental Health Benefits.

This Benefit Rider provides mental health and chemical dependency Benefits for the treatment of emotional conditions or chemical dependency listed as a mental disorder in the Diagnostic and Statistical Manual, as periodically revised, and which require professional intervention for as long as Services are considered Medically Necessary. These Benefits are subject to all the provisions, limitations, and exclusions of your medical Benefits that are listed in the Certificate.

If you have any questions regarding any aspect of the Benefits described in this Benefit Rider, please call the Behavioral Health Advocates℠ weekdays, from 8:00 a. m. to 6:00 p. m. at 801-442-1989 (Salt Lake area) or 800-876-1989.

2. Using Participating Mental Health Providers.

Mental health Services will be covered only when rendered by a Participating Provider unless otherwise noted on your Member Payment Summary.

3. Services requiring Preauthorization.

Preauthorization is required for all mental health and chemical dependency Services with the exception of office visits. If you need to request Preauthorization, call the Behavioral Health Advocates. Refer to Section 11 – "Healthcare Management" for additional information.

4. Exclusions.

4.1 The following Services are not covered:

a. Behavior modification;

b. Biofeedback;

c. Counseling with a patient's family, friend(s), employer, school authorities, or others, except for approved medically necessary collateral visits, with or without the patient present, in connection with otherwise covered treatment of the patient's mental illness;

d. Education or training;

e. Electrosleep or electronarcosis therapy;

f. Family counseling and/or therapy;

g. Long-term care;

h. Marriage counseling and/or therapy;

i. Methadone maintenance/therapy clinics or Services;

j. Milieu therapy;

k. Psychotherapy or psychoanalysis credited toward earning a degree or furthering your education or training;

l. Residential treatment (except as otherwise indicated on your Member Payment Summary);

m. Rest cures;

n. Self-care or self-help training (nonmedical);

o. Sensitivity training;

p. Surgical procedures to remedy a condition diagnosed as psychological, emotional, or mental, including but not limited to transsexual or sex change treatment; and

q. Neuropsychological testing for any of the following reasons:

   i. Autism spectrum disorder/pervasive developmental disorder

   ii. Chronic fatigue syndrome

   iii. Attention-deficit/hyperactivity disorder

   iv. When performed primarily for educational purposes

   v. When performed in association with vocational counseling or training

   vi. Learning disability

   vii. Mental retardation

   viii. Tourette's syndrome

4.2 In addition, Services for the following diagnoses are not covered:

a. Adjustment disorder;

b. Chronic organic brain syndrome;

c. Conduct disorder;

d. Diagnoses that refer to someone else's illness, such as family history of psychiatric condition, family history of mental retardation, family disruption, and/or alcoholism in the family;

e. Difficult life circumstance not part of treatment for a recognized mental illness;

f. Marital or family problems;

g. Mental retardation;

h. Personality disorder;

i. Psychosexual disorder such as transsexualism, psychosexual identity disorder, psychosexual dysfunction, or gender dysphoria;

j. Problems with gambling, theft, or fire setting;

k. Screening exams;

l. Separation anxiety;

m. Social, occupational, religious, or other social maladjustment; and

n. Specific developmental disorder or learning disabilities such as autism, attention-deficit/hyperactivity disorder, and pervasive developmental disorder.

ASH CHIROPRACTIC BENEFIT RIDER

Your Chiropractic Benefits are administered by American Specialty Health, Inc ("ASH"). If you have any questions, concerns, or complaints about your chiropractic Benefits, please call ASH Member Services Department at 800-678-9133, or write to the following address:

American Specialty Health, Inc.
Attn: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

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1. DEFINITIONS.

This Benefit Rider uses the following capitalized defined terms in addition to Section 16—"Definitions" of the Contract. If there is a conflict between these terms and those in Section 16, these terms prevail.

1.1 Administrative Appeals.

Administrative Appeals may result from Adverse Benefit Determinations that are based on issues that arise from administrative procedures.

Examples of Administrative Appeals may include the following scenarios:

a. Treatment plan was denied for not meeting authorization and/or claim timeframe requirements.

b. Necessary information was not received from Provider according to ASH timelines.

1.2 ASH Quality Management and Improvement ("QI") Program.

Those standards, protocols, policies, and procedures adopted by ASH to monitor and improve the quality of clinical care and quality of Services provided to you.

1.3 ASH Service Area.

The geographic area in which ASH arranges Chiropractic Services in Utah.

1.4 ASH Utilization Management ("UM") Program.

Those standards, protocols, policies, and procedures adopted by ASH regarding the management, review, and approval of the provision of Covered Chiropractic Services to you.

1.5 Chiropractic Appliances.

Chiropractic appliances are support-type devices prescribed by a Participating Chiropractor. Following are the only items that could be covered: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces/supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

1.6 Chiropractic Services.

The Services rendered or made available to you by a chiropractor for treatment or diagnosis of Neuromusculoskeletal Disorders.

1.7 Clinical Appeals.

Clinical Appeals may result from Adverse Benefit Determinations that are based on Medical Necessity, Experimental and/or Investigational treatment, or similar Exclusions or Limitations.

a. Examples of Clinical Appeals may include the following scenarios:

b. Treatment plan was denied or modified due to lack of Medical Necessity.

c. The number of visits requested by the Provider did not meet clinical criteria.

1.8 Covered Chiropractic Services.

The Chiropractic Services that ASH determines to be Medically Necessary, as limited by this Benefit Rider.

1.9 Emergency Chiropractic Services.

Services provided to manage an injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate clinical attention to result in:

a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part; or

d. Decreasing the likelihood of maximum recovery.

1.10 Medical Necessity/Medically Necessary.

Chiropractic Services that are:

a. Necessary, appropriate, safe, effective, and rendered in accordance with professionally recognized, valid, evidence-based standards

and guidelines that have been adopted by ASH for its use in determining whether Chiropractic Services are appropriate for reimbursement;

b. Directly applicable to the diagnosis and treatment of a covered condition;

c. Verified by ASH as being rendered for the purpose of reaching a defined and appropriate functional outcome or maximum therapeutic benefit (defined as your return to your pre-illness/pre-injury daily functional status and activity);

d. Rendered in a manner that appropriately assesses and manages your response to the clinical intervention;

e. Rendered for the diagnosis and treatment of a covered condition;

f. Rendered in accordance with the Clinical Services Management Program and Clinical Performance Management Program standards as published in the ASH Chiropractic Provider Operations Manual;

g. Appropriate for the severity and complexity of symptoms and consistent with the covered condition (diagnosis) and appropriate for your response to care; and

h. Not considered to be an elective Chiropractic Service or a Chiropractic Service for any condition that is not a covered condition. Examples of elective services are:

   i. Preventive maintenance services;

   ii. Wellness services;

   iii. Services not necessary to return you to pre-illness/pre-injury functional status

   iv. and activity; and

   v. Services provided after you have reached maximum therapeutic benefit.

1.11 Neuromusculoskeletal Disorders.

Neuromusculoskeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular, and/or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

1.12 Out-of-Area Services.

Those Emergency Chiropractic Services provided while you are outside the ASH Service Area that would have been the financial responsibility of ASH had the Services been provided within the ASH Service Area. Covered Chiropractic Services that are to be provided outside the ASH Service Area, and are arranged by ASH for assigned Members, are not considered Out-of-Area Services.

1.13 Participating Chiropractor.

A participating chiropractor is a chiropractor who is duly licensed to practice chiropractic in Utah and who has entered into an agreement with ASH to provide covered Chiropractic Services to you.

2. USING YOUR CHIROPRACTIC BENEFITS.

Using your chiropractic Benefits is easy. Simply use a Participating Chiropractor listed in the Chiropractic Provider Directory.

You may receive Covered Chiropractic Services from any Participating Chiropractor without a referral. Except for Medically Necessary Emergency Chiropractic Services, ASH will not pay for Services received from any nonparticipating Chiropractor.

3. PREAUTHORIZATION/UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.

After the initial examination, the Participating Chiropractor must obtain Preauthorization for any additional Covered Chiropractic Services that you receive. The Participating Chiropractor will be responsible for filing all claims with ASH. You must cooperate with ASH in the operation of its Utilization Management and Quality Improvement Programs.

4. EMERGENCY CHIROPRACTIC SERVICES.

You may receive Emergency Chiropractic Services from any chiropractor, including an out-of-network chiropractic Provider if the delay caused by seeking immediate chiropractic attention from a Participating Chiropractor could decrease the likelihood of maximum recovery. ASH will pay the out-of-network chiropractic Provider for the Emergency Chiropractic Service to the extent they are Covered Chiropractic Services.

5. TYPES OF COVERED CHIROPRACTIC SERVICES.

Each office visit to a Participating Chiropractor, as described below, requires a Copay by you at the time Covered Chiropractic Services are provided. A maximum number of visits per calendar Year will apply to each Member as specified in your Member Payment Summary.

a. A new patient examination is performed by a Participating Chiropractor to determine the nature of your problem, and if Covered Chiropractic Services appear warranted, a clinical treatment form of Services is prepared by the Participating Chiropractor. A new patient examination will be provided for each new patient. A Copay will be required.

b. An established patient examination may be performed by the Participating Chiropractor to assess the need to continue, extend or change a clinical treatment form approved by ASH. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copay is required.

c. Subsequent office visits, as set forth in a clinical treatment form approved by ASH, may involve an adjustment, a brief re-examination, and other Services in various combinations. A Copay will be required for each visit to the office.

d. Adjunctive therapy, as set forth in a clinical treatment form approved by ASH, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation, and other therapies.

e. X-rays and lab tests are payable in full when prescribed by a Participating Chiropractor and authorized by ASH. Radiological consultations are a covered Benefit when authorized by ASH as Medically Necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or Hospital that has contracted with ASH to provide those services.

f. Chiropractic appliances are payable up to a maximum of $50.00 per year when prescribed by a Participating Chiropractor and approved by ASH.

6. CHIROPRACTIC EXCLUSIONS AND LIMITATIONS.

ASH will not pay for or otherwise cover the following:

a. Any Services or treatments not authorized by ASH, except for a new patient examination and Emergency Chiropractic Services;

b. Any Services or treatments not delivered by a Participating Chiropractor for the delivery of chiropractic care to you, except for Emergency Chiropractic Services;

c. Services for examinations and/or treatments for conditions other than those related to Neuromusculoskeletal Disorder;

d. Hypnotherapy, behavior training, sleep therapy, and weight programs;

e. Thermography;

f. Services, lab tests, x-rays, and other treatments not documented as Medically Necessary, as appropriate, or classified as Experimental and/or Investigational, or as being in the research stage, as determined in accordance with professionally recognized standards of practice;

g. Services that are not documented as Medically Necessary;

h. Magnetic resonance imaging (MRI), CAT scans, and any types of diagnostic radiology;

i. Transportation costs including local ambulance charges;

j. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing;

k. Services or treatments for pre-employment physicals or vocational rehabilitation;

l.

m. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;

n. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances, all chiropractic appliances, or Durable Medical Equipment, except as specified herein;

o. All chiropractic appliances or Durable Medical Equipment, except as specified herein;

p. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;

q. Services provided by a chiropractor practicing outside of Utah, except for Emergency Chiropractic Services.

r. Hospitalization, anesthesia, manipulation under anesthesia, or other related services;

s. All auxiliary aids and services, including interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids;

t. Adjunctive therapy not associated with spinal, muscle, or joint manipulation; and

u. Vitamins, minerals, nutritional supplements, or other similar products.

7. THIS BENEFIT RIDER.

This Rider is subject to all provisions, Limitations, Exclusions, and agreements of the Certificate of Coverage and the Contract (available from your employer).

8. CLAIMS AND APPEALS.

ASH will follow administrative processes and safeguards designed to ensure and to verify that Benefit claim determinations are made in accordance with the provisions of this Rider administered by ASH and that the provisions have been applied consistently with respect to similarly situated Claimants. This section uses the following additional (capitalized) defined terms:

8.1 Adverse Benefit Determination.

Any of the following: a denial, reduction, or termination of a claim for Benefits, or a failure to provide or make payment for such a claim in whole or in part, including determinations related to a Claimant's eligibility, the application of a review under ASH Utilization Management Program, and determinations that particular care or treatment is Experimental and/or Investigational or not Medically Necessary or appropriate.

8.2 Authorized Representative.

Someone you have designated to represent you in the claims or appeals process. To designate an

Authorized Representative you must provide written authorization on a form provided by the ASH Member Services department or ASH Grievance and Appeals department. However, where an Urgent Preservice Claim is involved, a healthcare professional with knowledge of the medical condition will be permitted to act as your Authorized Representative without a prior written authorization. In this Benefit Rider, the words "you" and "your" include your Authorized Representative.

8.3 Benefit Determination.

The decision by ASH regarding the acceptance or denial of a claim for Benefits under this Rider.

8.4 Claimant.

Any Subscriber or Member making a claim for Benefits. Claimants may file claims themselves or may act through an Authorized Representative. In this section, the words "you" and "your" are used interchangeably with Claimant.

8.5 Post-Service Claim.

Any claim related to care or treatment that has already been received by the Member.

8.6 Preservice Claim.

Any claim related to care or treatment that has not been received by the Member.

8.7 Urgent Preservice Claim.

Any Preservice Claim that if subject to the normal timeframes for determination could seriously jeopardize your life, health, or ability to regain maximum function or that, in the opinion of your treating chiropractor, would subject you to severe pain that could not adequately be managed without the requested Services. Whether a claim is an Urgent Preservice Claim will be determined by an individual acting on behalf of ASH applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that your treating chiropractor determines is an Urgent Preservice Claim will be treated as such.

8.8 How to Make a Preservice Inquiry.

Preservice Inquiries should be directed to ASH Member Services at 1-800-678-9133.

8.9 How to File a Claim for Benefits.

You are responsible for submitting all Preservice, Urgent-Care, and Post-Service claims to ASH. Under certain circumstances provided by federal law, if you fail to follow the proper procedures for filing a claim, ASH will provide notice of the failure and describe the proper procedures to be followed. This notification will be provided as soon as reasonably possible, but not later than five days after the receipt of the claim and may be oral unless you specifically request it in writing.

8.10 Timing of Benefits Determinations.

ASH will make and notify your Provider and you, or your Authorized Representative, of its Benefits determinations as follows:

a. Urgent Preservice Claim.

Notice of a Benefit Determination will be provided as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of the claim. However, if ASH gives you notice of an incomplete claim, the notice will give you at least 48 hours to provide the requested information. ASH will provide a notice of Benefit Determination within 48 hours after receiving the specified information, or the end of the period of time given you to provide the information, whichever occurs first. If the Benefit Determination is provided verbally, it will be followed in writing no later than three days after the verbal notice.

b. Other Preservice Claims.

Notice of a Benefit Determination will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. However, ASH may extend this period for up to an additional 15 days if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you with written notice, prior to the end of the original 15 day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least 45 days from your receipt of the notice to provide the requested information.

c. Post-Service Claims.

Notice of a Benefit Determination will be provided in writing within a reasonable period of time, but not later than 30 days after receipt of the claim. However, ASH may extend this period for up to an additional 15 days if ASH: 1) determines that such an extension is necessary due to matters beyond its control; and 2) provides you written notice, prior to the end of the original 30 day period, of the circumstances requiring the extension and the date by which ASH expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be given at least 45 days from your receipt of the notice to provide the required information.

The applicable time period for the Benefit Determination begins when your claim is filed in accordance with ASH's procedures, even if you have not submitted all the information necessary to make a Benefit Determination. However, if the time period for the Benefit Determination is extended due to your failure to submit information necessary to decide a claim, the time period for making the Benefit Determination will be suspended until the earlier of: 1) the date on which you respond to the request for additional information, or 2) the date established by ASH for the furnishing of the requested information (at least 45 days).

8.11 Notice of Adverse Benefit Determinations.

If your claim is subject to an Adverse Benefit Determination, you will receive a notification that includes:

a. The specific reason(s) for the Adverse Benefit Determination;

b. Reference to the specific provisions on which the Adverse Benefit Determination was based;

c. A description of any additional information or material needed from you to complete the claim and explanation of why it is necessary;

d. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the Adverse Benefit Determination and that a copy of the rule, guidelines, protocol, or other criterion will be provided upon request free of charge;

e. If the Adverse Benefit Determination was based on a Medical Necessity, Experimental and/or Investigational treatment, or similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;

f. If an Urgent Preservice Claim was denied, a description of the expedited review process applicable to the claim; and

g. A description of ASH review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under Employee Retirement Income Security Act (ERISA) Section 502(a) with respect to any claim denied after an appeal.

8.12 Problem Solving.

ASH is committed to making sure that all of your concerns or problems are investigated and resolved as soon as possible. Most situations can be resolved informally by contacting ASH Member Services at 800-678-9133.

8.13 Formal Appeals.

If you are not satisfied with the result of working with ASH Member Services, you may request a formal appeal either verbally or in writing of any Adverse Benefit Determination or the negative outcome of a Preservice Inquiry. Written formal appeals should be sent to the ASH Appeal and Grievance department. As the delegated claims review fiduciary, ASH will conduct a full and fair review of your appeal and has final discretionary authority and responsibility for deciding all matters regarding eligibility and coverage.

a. General Rules and Procedures. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, and other information relevant to your claim for Benefits. You will also have the opportunity to submit written comments, documents, records, and other information relating to your appeal. ASH will consider this information regardless of whether it was considered in the Adverse Benefit Determination.

   At each level in the appeal process decisions will be made by ASH personnel who did not make the Adverse Benefit Determination and who do not report to anyone who did. If the Adverse Benefit Determination was based on medical judgment, including determinations that Services are Experimental and/or Investigational or not Medically Necessary, ASH personnel at each applicable level will consult with a medical professional with appropriate training and experience in the appropriate field of medicine and who was neither consulted in connection with the Adverse Benefit Determination nor is the subordinate of such an individual. Upon request, you will be provided the identification of any medical expert(s) whose advice was obtained on behalf of ASH in connection with the Adverse Benefit Determination, whether or not the advice was relied upon in making the Adverse Benefit Determination.

b. Form and Timing. All requests for a formal appeal of an Adverse Benefit Determination (other than those involving an Urgent Preservice Claim) must be in writing and should include a copy of the Adverse Benefit Determination and any other pertinent information that you want ASH to review in conjunction with your appeal. Send all information to the ASH Appeals Coordinator at the following address:

   ASH Appeals Coordinator
   P.O. Box 509001
   San Diego, CA 92150-9002

   You may also request a formal appeal of an Adverse Benefit Determination verbally by calling ASH at 800-678-9133.

   If the request is made verbally, ASH will within 24 hours, send written confirmation acknowledging the receipt of your request.

You must file a formal appeal within 180 days from the date you received notification of the Adverse Benefit Determination or made the Preservice Inquiry, as applicable.

Appeals that do not comply with the above requirements are not subject to review by ASH or other challenge.

c. Mandatory and Voluntary Appeal Levels. As described below, the formal appeals process differs for Clinical and Administrative Preservice Claims and Post-Service Claims. In each case, there are both mandatory and voluntary levels of review. For purposes of the formal appeals process only, Preservice Inquiries will be treated like Preservice Claims.

You must exhaust all mandatory levels of review before you may pursue civil action under ERISA Section 502(a). It is your choice, however, whether or not to seek voluntary levels of review, and you are not required to do so before pursuing civil action under ERISA Section 502(a). ASH agrees that any statute of limitations or other legal defense based on timeliness is suspended during the time that any voluntary appeal level is pending. Your decision whether or not to seek voluntary levels of review will have no effect on your rights to any other Benefits under the Plan. ASH will provide you, upon request, sufficient information to enable you to make an informed judgment about whether or not to engage in a voluntary level of review.

ASH resolves each level of appeal for Preservice Claims (both Clinical and Administrative) within 15 calendar days from receipt of the appeal request. ASH resolves the mandatory appeal review levels for Urgent Preservice Claims (both Clinical and Administrative) within 72 hours from receipt of the appeal request.

i. The Appeals Process for Clinical Appeals. The formal process for appealing a clinical Adverse Benefits Determination consists of two mandatory review levels, two voluntary review levels, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review—Level 1

Upon receipt of your appeal request, a senior clinical services manager and at least one consumer representative conducts the first mandatory level of appeal for clinical appeals. If more information is needed, a letter is sent to the treating Provider requesting additional information. If you are dissatisfied with the decision, you may request a second level mandatory appeal. You have 45 days from the date of the decision to file an additional appeal request.

Mandatory Review—Level 2

If you are dissatisfied with the outcome of the first mandatory level of appeal, the ASH director or senior clinician in the like specialty of the treating Provider and at least one consumer representative will conduct the second mandatory level of appeal for clinical appeals. If the director or senior clinician denies the appeal, the director or senior clinician will consult with a Participating Chiropractor.

If you are dissatisfied with the decision, you have the option to pursue the following levels of voluntary appeals:

Voluntary Review—Level 1: Independent Review Organization (IRO)

If you are dissatisfied with the outcome of the second mandatory level of appeal, you may request a voluntary level of appeal through an IRO. An IRO is an independent external review organization that is not connected in any way with ASH. The IRO engages health care professionals with the appropriate level and type of clinical knowledge and experience to properly judge an appeal. There is no cost to you for a voluntary IRO appeal.

Voluntary Review—Level 2: Voluntary, Binding Arbitration

If you are dissatisfied with the outcome of the first voluntary level of appeal, you may request a second voluntary level of appeal consisting of binding arbitration through the American Arbitration Association (AAA). To initiate the arbitration process, you may contact AAA at 1-800-778-7879. You will not be responsible for any charges or fees associated with voluntary dispute resolution options.

Any matter of dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the rules of the AAA or other recognized arbitrator, a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Civil Action

At any point after the mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge ASH original decision.

ii. The Appeals Process for Administrative Appeals. The formal process for appealing an Administrative Adverse Benefit Determination

consists of two mandatory review levels, two voluntary review levels, and the right to pursue civil action under ERISA Section 502(a).

Mandatory Review—Level 1: Administrative Appeals Committee (AAC)

Upon receipt of your appeal request, the ASH AAC, which consists of ASH managers and at least one consumer representative, conducts the first mandatory level of appeal for administrative appeals. The AAC evaluates the appeal and renders a decision regarding the appeal and may make recommendations for resolution of Member issues. If you are dissatisfied with the decision of the AAC, you may request a second level mandatory appeal. You have 45 days from the date of the decision to file an additional appeal request.

Mandatory Review—Level 2: Administrative Review Committee (ARC)

If you are dissatisfied with the outcome of the first mandatory level of appeal, the ASH ARC, which consists of ASH officers, directors, employees, and at least one consumer representative, conducts the second mandatory level of appeal to administrative appeals. The ARC evaluates the appeal and renders a decision regarding the appeal and may make recommendations for resolution of Member issues. You have 45 days from the date of the decision to file an additional appeal request.

If you are dissatisfied with the decision, you have the option to pursue the following levels of voluntary appeals.

Voluntary Review—Level 1: Executive Review Committee (ERC)

If you are dissatisfied with the outcome of the second mandatory level of appeal, you may request a voluntary level of appeal by the ASH ERC, which consists of ASH senior officers and one contracted chiropractor. The ERC evaluates the appeal and renders a decision regarding the appeal. There is no cost to you for a voluntary ERC appeal.

Voluntary Review—Level 2: Voluntary, Binding Arbitration

If you are dissatisfied with the outcome of the first voluntary level of appeal, you may request a second voluntary level of appeal consisting of binding arbitration through the AAA. To initiate the arbitration process, you may contact AAA at 1-800-778-7879. You will not be responsible for any charges or fees associated with voluntary dispute resolution options.

Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the rules of the AAA or other recognized arbitrator, a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Civil Action

At any point after ASH mandatory review process, you may choose to pursue civil action under ERISA Section 502(a). Failure to properly pursue the mandatory appeals process may result in a waiver of the right to challenge ASH original decision.

d. Notification of Appeal Decision. At each applicable level of the appeals process described above, if your appeal is denied, ASH's written notification will include the following information:

   i. The specific reason(s) for the Adverse Benefit Determination;

   ii. Reference to the specific provision(s) on which the Adverse Benefit Determination was based;

   iii. A statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the claim;

   iv. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided upon request free of charge;

   v. If the denied appeal was based on a Medical Necessity, Experimental and/or Investigation treatment, or a similar Exclusion or Limitation, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided upon request free of charge;

   vi. A list of titles and qualifications or the individuals participating in the review; and

   vii. A statement describing any additional mandatory or voluntary appeal levels either required or offered by ASH, including the opportunity for IRO assessment, if applicable, your right to obtain information about such procedures, and a statement of your right to bring suite under ERISA Section 502(a).

e. Notification of the decision on an Urgent Preservice Claim may be provided verbally, but a follow-up written notification will be provided no later than three days after the verbal notice.

DOMESTIC PARTNER RIDER

1. YOUR DOMESTIC PARTNER BENEFITS.

This Benefit Rider provides coverage for domestic partners when the following criteria are met:

A person of the same or opposite sex who:

a. shares the employee's permanent residence;

b. has resided with the employee for no less than 12 months;

c. is not younger than 18;

d. is not married to, or is not a Domestic Partner or tax dependent of, another person;

e. is not so closely related by blood to the employee that a legal marriage would otherwise be prohibited;

f. has either 1) registered as a Domestic Partner with the employee in a state, city, or county which has a registration procedure for the Domestic Partners or 2) signed jointly with the employee in a notarized "Declaration of Domestic Partnership" that is submitted to the Employer; and

g. is financially interdependent with the employee and has proven such interdependence to the Employer by providing documentation of at least two of the following arrangements:

   i. common ownership of real property or a common leasehold interest in such property;

   ii. common ownership of a motor vehicle;

   iii. a joint bank account or a joint credit account;

   iv. designation as a beneficiary for life insurance or retirement benefits or under the employee's will;

   v. assignment of durable power of attorney;

   vi. such other proof as is considered by the Employer to be sufficient to establish financial interdependency under the circumstances of the particular situation.

2. ELIGIBILITY.

h. You may enroll yourself, a Domestic Partner, and Dependents of the Domestic Partner in the Employer's Plan during your Initial Eligibility Period, during an Annual Open Enrollment period, or under a Special Enrollment Right.

i. If you are enrolled in this coverage (or are eligible to be covered but declined during a previous enrollment period), and gain a Domestic Partner, then you may enroll the Domestic Partner (and yourself), if not otherwise enrolled) in the Employer's Plan within 31 days of certification of the partnership.

j. You may terminate the coverage of a Domestic Partner when: 1) the Domestic Partner dies; 2) the Domestic Partnership ends and you submit a "Declaration of Termination of a Domestic Partnership" to your Employer; 3) the Domestic Partner marries; or 4) you stop sharing the same principal residence with the Domestic Partner.

k. Once you terminate the coverage of a Domestic Partner, you must wait 12 months from the termination of such partnership to provide coverage for a former or new Domestic Partner.

l. Your employer must treat Domestic Partners the same as married individuals for all its employee health benefits plans.

m. Your employer must ensure that all other carriers providing employee health coverage offer Domestic Partner coverage with provisions similar to SelectHealth's.